AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Gary R Hubbard DDS and/or B Curtis Neal DDS Great Lakes Family Dental Group

Address: 3515 Coolidge Road Ste. C

City: East Lansing State: MI Zip Code: 48823

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: Current Full Mouth Radiographs/Panoral radiographs within the past 5 years and current BWX

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.