



LOUIS F. CLARIZIO, DDS PA
ORAL SURGERY & DENTAL IMPLANT CENTER
DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

**AUTHORIZATION TO RELEASE
MEDICAL INFORMATION**

From _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____ Fax _____

I authorize you to furnish a copy of medical records:

To _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Limitations/Exclusions (if any) _____

READ CAREFULLY

I have authorized the release of all information and/or medical records to such diagnosis, testing or treatment, unless specifically excluded. I understand that you cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information to be furnished. This request is a free voluntary act by me. I hereby release you and your staff from all legal responsibility that may arise from the release of the medical information hereby authorized.

Please list information that you are authorizing to be sent _____

Patient/Guardian Signature _____ Date _____

Print Patient Name _____ D.O.B. _____

Maiden or Previous Name _____

SS# _____