AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Darrel J. Gilbert, D.D.S.
6667 Vernon Woods Drive, Suite B-30
Sandy Springs, GA 30328

404 255-7047
404 843-1273 FAX
gilbertchalef@gmail.com

I hereby authorize the release of my dental records (x-rays)

Name of patient:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____Fax:_____

To:_____
(doctor's name)

Address:_____

Date of records (if known)_____

Patient's signature:_____

Guarantor's signature: (if minor)_____