RothDental
Care

Gary D. Roth, DDS-Alex J. Roth, DDS-Melanie Norton, DDS

Authorization for Release of Information

Patient Name_____________________________________Date of Birth_________________

If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Roth Dental Care to release my medical and/or billing information to the following individual(s):

1_____________________________________Relationship to Patient___________________

2_____________________________________Relationship to Patient___________________

3_____________________________________Relationship to Patient___________________

This Release of Information will remain in effect until terminated by me in writing.

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Signature of the Individual Giving This Authorization Date