melrose
Family Dentistry

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Date:_____

To whom it may concern:

I authorize the release of all medical information and xrays for myself and/or my dependents to be forwarded to:

MELROSE FAMILY DENTISTRY

smile@melrosefamilydentistry.com

Email is preferable for all digital imaging.

Individual signatures are required for each patient over the age of 18 in accordance with the HIPAA privacy act.

Print Name & Date of Birth	Signature (parent or guardian if under 18)
_____	_____
_____	_____
_____	_____
_____	_____