COLLEGE HILL DENTAL

# RELEASE OF INFORMATION

*Name of Patient_____ DOB: _____*

*I hereby authorize _____ to disclose records*

*Obtained in the Course of my dental diagnosis and treatment to:*

*College Hill Dental*

*Dr. Ivan Paskalev DMD*

*Family Dentistry*

*I understand that the requester may not further disclose the information unless another authorization is obtained from me or unless discloser is specifically required or permitted by law.*

*Signed: _____ Date: _____*

*If other than patient please indicate relationship: _____*

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