Vevera Family Dental
1980 N. Atlantic Ave
Suite 1002
Cocoa Beach, FL 32931
321-236-6606

Patient: ______________________________ **Date:** ______________________________

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes emails and /or photocopies of medical and/or dental histories, x-rays, x-ray findings, diagnosis, treatment, prognosis and financial records.

I request that you release the above information to:

____
Name

____
Address

____
City State Zip

____
Date Patient's (or legal guardian's) Signature Witness

Revised 3/09