PEORIA ORAL & IMPLANT SURGERY
AUTHORIZATION RELEASE FORM FOR MEDICAL/DENTAL RECORDS

By signing this document, I (Patient or Legal Guardian) authorize any doctor, administrator, agent, or other employee of Peoria Oral & Implant Surgery to obtain and/or release the following medical/dental information: medical/dental history, x-rays, medical insurance, dental insurance, treatment plan, billing, accounting disclosures or any other information related to my medical/dental record. I also otherwise any doctor, administrator, agent, or other employees of Peoria Oral & Implant Surgery to speak with any individual regarding my medical/dental information.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

Please release these records to:
Name:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Fax:_____ Email:_____

Please send my records to:
Dr. Nino Pollaccia and Staff
Peoria Oral & Implant Surgery
10210 W. Happy Valley Rd. Suite #150
Peoria, AZ 85383
P: 623-230-2297
F: 623-239-3547
Email: info@peoriaoralsurgery.com

Print Patient (Legal Guardian) Name/Relationship:_____
Patient (Legal Guardian) Signature: _____
Date:_____