Authorization of Release of Dental/Medical/Financial Information

I_____on this date_____ authorize Madison Dental Group, PLLC to release any of my dental/medical/financial information to the following person/persons (if none, please write n/a in the blanks below):

Authorized person:_____

Authorized person:_____

I may at any time unauthorize any of the above names to be released from obtaining my information with a written letter from me.

My signature above also gives my permission for Madison Dental Group, PLLC to release my dental/medical records to other medical offices when working in conjunction with Madison Dental Group for my care.