Progressive Oral Surgery
& Implantology of Long Island

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.

Name of Patient: _____ Birthdate: _____

Address: _____

_____

Phone Number: _____ Email: _____

Name of Guardian or Legal Representative: _____

Address: _____

_____

Phone Number: _____ Email: _____

Person|Organization to release information: _____

Address: _____

_____

Phone Number: _____ Email: _____

Fax: _____

Patient|Parent|Guardian Signature: _____

Witness Signature: _____

Notary:

Signature: _____

Date: _____

23 Bond Street|Great Neck, NY 11021|T 516-482-0329|F 516-482-0401
601 Franklin Ave|Suite 110|Garden City, NY 11530|T 516-741-4415|F 516.741-4417
37-06 82nd St|Suite 304|Jackson Heights, NY 11372|T 718-565-8800|F 718-565-2729
2035 Lakeville Road|Suite 204|New Hyde Park, NY 11040|T 516-437-2666|F 516-358-6954

WWW.PROGRESSIVEORALSURGERY.COM