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PATIENT AUTHORIZATION FOR RELEASE OF RECORDS

I,________________________________ authorize Dr. E. Charles Beliveau to release
(patient, parent or guardian)

records, relevant to dental treatment, or copies of such for the family members listed below:

Name: ________________________________ Relationship: ______________
________________________________ ______________
________________________________ ______________
________________________________ ______________
________________________________ ______________

Office Name: ________________________________

Dentist: ________________________________

Address: ________________________________
(Street)

City/State/Zip Code: ________________________________
(City/State/Zip Code)

Signature:___________________________ S.S.#:__________________Date: _______
(patient, parent,guardian)
Witnessed by__________________________________

Records will be released up to 30 days from signed authorization date