RECORDS RELEASE

ONE FINE SMILE
1100 Lake Street Suite 140
Oak Park, IL 60301
(708)383-1234

Date of Request _____

My permission is granted to Dr. _____ to disclose to _____
complete information concerning the medical findings and treatment of

_____
Patient

From _____ to _____
Date Date

I release Dr. _____
From any laws related to disclosure of confidential or privileged information.

Signature _____
Patient or Person Authorized to Consent for Patient

Address _____

Witness _____ Date _____