Authorization to Release Health Care Information

Patient's Name: ______________________________
DOB: ___________________________
Maiden Name: ______________________________
SSN: ___________________________

I request and authorize ______________________________ to release health care information of the patient named above to:

Kristina Neda, DMD
Jordan Smith, DMD
116 Market Place Circle Ste. A
Georgetown, KY 40324

This request and authorize applies to:

- Health information relating to the following treatment, condition or dates: ____
- All health information
- Other: ____ _________________________

_______________________ _______________
Patient's Signature Date

This authorization will expire 90 days after it is signed.