AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION *TO* DR. MELTZER'S OFFICE

I authorize the release of all information regarding my condition to be sent to Dr. Meltzer while under his observation or treatment, including the history obtained, radiographs, photographs, models, and physical findings diagnosis and prognosis.

_____
Patient Name

_____
Signature Date

AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION *FROM* DR. MELTZER'S OFFICE

□ to my dentist/physician
□ to my insurance carrier
□ other _____

I authorize the release of all information regarding my condition while under your observation or treatment, including the history obtained, radiographs, photographs, models, and physical findings diagnosis and prognosis.

_____
Patient Signature Date

□ I give authorization to notify me, by postcard and/or leaving a message for appointments or other pertinent information regarding my dental treatment.

_____Patient Initials