UNIQUE DENTAL CARE, PLLC

AUTHORIZATION TO RELEASE INFORMATION TO ANOTHER PERSON

Please complete this form in order for **Unique Dental Care, Pllc** to authorize and disclose personal information, account information and clinical information to another individual. You are asked to provide your information only to facilitate the identification and approval of your request.

(PLEASE PRINT PATIENT & REPRESENTATIVE INFORMATION and sign where appropriate).

Patient Information:

Name: _____ Address: _____

Tele#: _____ City: _____ State:_____ Zip:_____

Signature:_____ Date:_____

Representative Information:

Name: _____ Address: _____

Tele#: _____ City: _____ State:_____ Zip:_____

Signature:_____ Date:_____

I authorize **Unique Dental Care, Pllc** to release any and all information regarding my personal, account and clinical information to my Representative.

_____ _____

Patient Signature Date

09/2013