Authorization for Release of Information

I authorize Woodstock Family Dental to release my dental, medical, and personal information as necessary for my care. This authorization includes, but is not limited to, dental and medical records, radiographs (X-rays), treatment information, insurance information, and information shared with dental laboratories. This information may be released to dental and medical providers, insurance companies, and dental laboratories as deemed necessary to coordinate care, process claims, and provide proper treatment.

Signature: _____
Date: ____ / ____ / _____