SUMRALL DENTAL CLINIC
P.O. BOX 469
4556 HWY 589
SUMRALL, MS 39482
TEL: (601) 758-0150 FAX: (601)758-0149

RELEASE OF PATIENT INFORMATION

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

☐ I **DO NOT** AUTHORIZE ANY INFORMATION TO BE RELEASED TO ANYONE OTHER THAN PARENT/LEGAL GUARDIAN OF A MINOR.

☐ I AUTHORIZE ANY INFORMATION TO BE RELEASED AS NECESSARY.

☐ I AUTHORIZE SUMRALL DENTAL CLINIC TO RELEASE INFORMATION, CONCERNING THE PATIENT LISTED ABOVE, TO THE FOLLOWING:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN ***DATE***