AUTHORIZATION FOR RELEASE OF RECORDS

I,_____, have requested copy of the Dental records

of,_____, to be sent to:

MARIE A ALBANO DDS INC.
14601 DETROIT AVE. #680
LAKEWOOD, OHIO 44107

I hereby release _____ from all legal responsibility or liability relating to the release, disclosure and examination of confidential dental information.

Date: _____ _____
Print Patient Name

- _____
Signature of Patient or guardian

_____
Relationship to patient

Date: _____ _____
Witness