



**O'Leary Dental Office**  
**2004 W Court Street**  
**Janesville WI 53548**  
[www.olearydental.com](http://www.olearydental.com)

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize \_\_\_\_\_  
 (Doctor or Clinic)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: (     ) \_\_\_\_\_

To release the following information from my health care records

1. Medical/Health file
2. Office Notes
3. Narrative Reports
4. X-Rays
5. \_\_\_\_\_

And request they be released to :

- |   |   |
|---|---|
| <input type="checkbox"/> <b>O'Leary Dental Office</b><br><a href="mailto:Julie@olearydental.com">Julie@olearydental.com</a><br><b>2004 W Court Street</b><br><b>Janesville WI 53548</b> | <input type="checkbox"/> _____<br><b>EMAIL:</b> _____<br>_____<br>_____ |
|---|---|

\_\_\_\_\_  
 Print Name of Patient Date of Birth

**X** \_\_\_\_\_  
 Patient Signature Date of Signature