O'Leary Dental Office
2004 W Court Street
Janesville WI 53548
www.olearydental.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authourize____
(Doctor or Clinic)

Address____

City____________________ State___________ Zip Code____________________

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 :

O'Leary Dental Office
2004 W Court Street
Janesville WI 53548

____
Print Name of Patient   Date of Birth

____
Patient Signature   Date of SIgnature