Ed Brents, D.M.D.
103 Fee Street
Berea, Ky 40403
(859) 986-3346
Fax (859) 986-4530

**PATIENT'S AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION**

To: _____

_____

_____

Patient's Name: _____

DOB: _____

SS#: _____

Dear Health Care Provider,

I hereby authorize the healthcare provider whose name appears above to release to Ed Brents, D.M.D. any information acquired in the course of examination or treatment as well as any dental radiographs which relate to treatment of the above named patient. I further allow a photocopy of my signature to be used for this purpose.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

_____ _____
WITNESS DATE