RECORDS RELEASE AUTHORIZATION

To: _____

Doctor or Hospital

_____

Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Frederick H. Suter, D.D.S
Neal R. Levitt, D.D.S. LLP
William E. Zugner, D.D.S
55 North Ave.
Webster, NY 14580

THE COMPLETE HISTORY RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM _____ TO _____

NAME _____ DATE _____

ADDRESS _____

SIGNATURE _____ WITNESS _____

(IF RELATIVE STATE RELATIONSHIP)