Rebecca A. Zerngast, DDS
Carrie K. York, DDS
PLLC

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient name______________________ Date of birth____________________

Previous name_________________________

I request and authorize____
to release original dental records of the patient named above to:

Rebecca A. Zerngast, DDS
Carrie. K York, DDS

____
Signature of patient or patient's authorized representative Date

____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)