AUTHORIZATION TO RELEASE MEDICAL RECORDS

This will authorize ___________________________to release any and all records, radiographs, and other medical information in your care and control concerning the health and physical condition of the undersigned to Mac Dental "Designee."

This authorization will be your authority to permit the Designee to obtain copies of any and all of the above described records concerning the health and physical condition of the undersigned. It is expressly understood by the undersigned that you are hereby authorized to accept a copy or photocopy of this authorization with the same validity as though the original had been presented to you. Please email to **info@macdental nixa.com**

Dated this __________day of ______________, 20___.

____
Patient Printed Name

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Patient Signature