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And Associates
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Authorization for Release of Medical/Dental Information

I, _________________________________ authorize Joel E. Toupin, DDS, John A. Toupin, DDS, PC to release the following dental records to _____________ ______.

Patient or Dentist Name: ____

Patient or Dentist Address: ____

City, State, Zip: ____

This information is being released for Dental Purposes Only and may not be used for any other purpose or released to any other person (s) without my written consent.

______ Any record of testing, care, treatment, reporting or research pertaining to communicable diseases such as, Tuberculosis, Hepatitis, and HIV or any other related diseases.

This release is effective for six months from the date of execution; however, I may revoke it at any time by providing notice in writing to the above named party.

S/: __________________________ Date: ________________________
Patient/Legal Guardian of Patient

S/: __________________________
Witness