Battlefield Dental of Fredericksburg
5996 Plank Road
Fredericksburg, VA 22407

Authorization to Release Healthcare Information

I, _____ authorize the staff of Battlefield Dental of Fredericksburg Inc. to release and share my healthcare information with the following entities:

Name: _____
Date of Birth: _____
Address: _____
_____
Phone Number: _____

This authorization is good for:
☐ One year ☐ Indefinitely ☐Other: _____

Any limitations to my records would be:
_____
_____
_____

Signature of patient/guardian/or authorized representative:

_____

Date:

_____