Patient Information Disclosure Authorization

Patient Name: ____ Date of Birth: ____________________

I authorize Martin Nelson Endodontic Group to disclose financial and insurance information and/or patient records to the following individuals or entities:

1. ____
2. ____
3. ____
4. ____
5. ____

Authorization valid until the following date or until permission is withdrawn.

Date: __________________________________

Patient or Legally Authorized Individual:

____ _____________________________________

Signature Date