MARTINEZ DENTAL SOLUTIONS

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative regarding:

□ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays, history, laboratory findings, diagnosis and prognosis records, doctor's and staff's notes and any other non-medical information in my file.

□ Only the following types of information:

_____

_____

_____

_____

The above information shall only be released to the following persons:

Family Member/Personal Representative	Relationship
_____	_____
_____	_____
_____	_____

This authorization shall remain valid (check one)

□ Until revoked in writing.

□ Until _____, 20_____.

I understand that I may terminate this Medical Authorization Form. To do so, I must notify this facility in writing regarding termination and effective date.

I know that I am entitled to receive a copy of this authorization.

Printed Name of Patient: _____

Signature of Patient or Legal Representative: _____

Printed Name of Legal Representative (if applicable): _____

Date: _____