AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please give this form to your previous dentist

Patient's Name: Date of Birth:

Address: Social Security #:

I request and authorize

To release healthcare information of the patient named above to:

Joshua H. Ehrlich, DMD PC
3118 N. Sheffield Ave. Ste. 1N
Chicago, IL 60657
Phone: (773) 935-0300
FAX: (773) 935-0302
ehrlichdental@gmail.com

☐ Yes ☐ No I authorize the release of any dental records, including xrays and tests to the person(s) listed above.

Patient Signature: Date Signed: