Niceforo & Braun D.D.S., P.C.
285 Main Street
East Aurora, NY 14052
716-652-1020
nicebraunnowak@gmail.com

AUTHORIZATION TO RELEASE DENTAL CARE INFORMATION

_____ _____
Patient Name **Date of Birth**

_____
Previous Name

I request and authorize the release dental care information of the patient named above to:

Name _____

Address _____

City _____

State _____ **Zip Code** _____

Email: _____

This request authorization applies to:

□ **Dental care information relating to the following treatment, condition or dates:**
_____

_____

□ **All dental care information.**

_____ _____
Patient Signature **Date Signed**

Email: nicebraunnowak@gmail.com