BEAUTIFUL SMILES
By Dr. Harold A. Pollack, D.D.S., P.A.

Patient Waiver for Release of Medical/Dental Records

This is to authorize any physician dentist, hospital, medical attendant, or others to furnish the office of Dr. Harold A. Pollack with any and all information or opinions, which he/she requests regarding my medical and/or dental treatment rendered; and to allow Dr. Harold A. Pollack to see, copy, or have copies made of any records, including radiographs, which relate to my condition and treatment. This also includes the verbal communication of any information contained in said records to the office named above.

I hereby waive any privilege or other legal right relative to the release of said information to Harold A. Pollack D.D.S.

Patient's Printed Name: _____

Patient's Signature: _____

Date: _____

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