Authorization for release of Medical Information

I hereby authorize Peter F. Hazim D.D.S. to release my medical or incidental information that may be necessary for medical care or to process medical insurance claims for which payment is assigned to the provider.

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I authorized that detailed messages may be left for the patient regarding patient care:

- ☐ At patient's/parent's work
- ☐ On home answering machine
- ☐ On Cell Phone
- ☐ With Parent/Spouse
- ☐ With Immediate Family Member
- ☐ Via E-mail

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Patient Name (Print) Date of Birth

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Patient/Guardian Signature Date