

**PREMIERE DENTISTRY OF TAHLEQUAH**  
**1205 E. ROSS BY-PASS**  
**TAHLEQUAH, OK 74464**  
**Telephone (918) 456-2555**  
**Fax (918) 456-2444**

Mark D. Smith, D.D.S. \_\_\_\_\_ R. Stephen Jones, D.D.S.

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I request and authorize **Premiere Dentistry** to release health care information of the patient named above to:

Practice/Dr.'s Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This request and authorization applies to:

- Treatment Records and Current X-rays

I authorize the release of all records regarding dental treatment to the person(s) listed above.

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE OF SIGNATURE**