AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION FROM DR. MATTHEW KUBOVICH D.D.S.

Name of Patient: _____

Name of Patient: _____

_____

Address City State Zip

Date of Birth _____/____/_____ Date of Birth:___/____/____

I hearby authorize Dr. Matthew Kubovich and his associates the right to

RELEASE TO: _____

(Name of doctor, hospital or dentist to RECEIVE information)

Dr. Address & Phone #:_____

Dr. Email _____

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

Dr. Matthew Kubovich and his associates, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ _____

Parent or Legal Guradian Signature Date

4949 Westown Pkwy • Suite 150 • WDM, IA 50266 • (515)225-0066 • fax: (515)226-0998