Authorization for the Release of Dental Records And Radiographs

I hereby authorize ________________________________, DDS/DMD to release the information and

recent radiographs in the dental record of: ____________________________________

to: **Daniel E. Hogan, D.M.D.**
101 S Washington Avenue
Suite 103
Park Ridge, IL 60068

Any and all information may be released including, but not limited to, mental health records, drug and/or alcohol abuse records which are protected by state or federal law, and/or HIV test results, if any, except as specifically provided below.

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____ ______________________
Signature Date

If not signed by the patient please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient