Date:_________________________________

Name:________________________________

Address:______________________________

City:_________________________________ State:___________ Zip Code:______________

I hereby authorize and request the release of my clinical records and radiographs for:

Name:_________________________________ SS#__________________________________

Name:_________________________________SS#___________________________________

Name:_________________________________ SS#___________________________________

Name:_________________________________ SS#___________________________________

To be released to the following:

Name:______________________________ Phone#:_________________________

Address:____

City:_______________________________ State:______________ Zip:___________

____ _________________

Patient's / Parent, Guardian Signature Date:

Brett R Warn DDS, 5103 NW Cache Road Lawton OK 73505

Office (580)-248-4224

Fax (580) 248-4299