

**AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION TO  
DR. MELTZER'S OFFICE**

I authorize the release of all information regarding my condition to be sent to Dr. Meltzer while under his observation or treatment, including the history obtained, radiographs, photographs, models, and physical findings diagnosis and prognosis.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**AUTHORIZATION FOR RELEASE OF TREATMENT INFORMATION FROM  
DR. MELTZER'S OFFICE**

- to my dentist/physician
- to my insurance carrier
- other \_\_\_\_\_

I authorize the release of all information regarding my condition while under your observation or treatment, including the history obtained, radiographs, photographs, models, and physical findings diagnosis and prognosis.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**I give authorization to notify me, by postcard and/or leaving a message for appointments or other pertinent information regarding my dental treatment.**

\_\_\_\_\_  
Patient Initials