CALOGERO VASSALLO DDS, PLLC

# Medical Information Release Form

Name: _____ Date of Birth: _____

## Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This Information may be released to:

- ☐ Spouse _____
- ☐ Child(ren)_____
- ☐ Other_____
- ☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

**Signature:** _____

**Date:**_____