

OFFICE OF JOHN MICHAEL TATE, DDS, PA
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AUTHORIZATION TO RELEASE HEALTHCARE/DENTAL INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare/Dental information relating to the following treatment and dates: _____

All Healthcare/Dental information

Other: _____

Patient Signature: _____ Date Signed: _____