<u>AUTHORIZATION FOR RELEASE OF RECORDS</u>

I, ____, have requested copy of the Dental records

of, ____, to be sent to:

BRUCE A. WEITZ DDS INC.
1700 COOPER FOSTER PK RD W, #B
LORAIN, OH 44053

I hereby release ____ from all legal responsibility or liability relating to the release, disclosure and examination of confidential dental information.

Date: _______________________________

____
Print Patient Name

____
Signature of Patient or guardian

____
Relationship to patient

Date: _______________________________

____
Witness