

**AUTHORIZATION FOR US TO RELEASE MEDICAL INFORMATION**

I hereby authorize Dr. Gilleland to release any medical/dental information regarding myself or my child to my physician, insurance company, lawyer, or anyone else specifically named by me. This information includes records, and/or referring physicians reports or copies thereof.

I have read this statement carefully. I understand it completely and sign without any reservations, not even the slightest doubt.

SIGNATURE\_\_\_\_\_

DATE\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I hereby authorize any physician, hospital, clinic or other medical facility, or any other persons having any records or knowledge of me or my health, or that of my child, to give Dr. Gilleland any and all information regarding the undersigned or my child, or copies thereof, which may be pertinent to my owner or my child's dental care.

SIGNATURE\_\_\_\_\_

DATE\_\_\_\_\_