Please note that any providers/family members/attorneys/etc. that you list below may receive a copy of your consultation report(s) unless you specify that we not release your medical records to those listed below.

Referring Physician:

Address:

Phone Number:

Primary Care Physician:

Address:

Phone Number:

Primary Care Dentist:

Address:

Phone Number:

If there is anyone else you would like to receive information regarding your care in this office please list below:

Name:

Address:

Phone Number

Name:

Address:

Phone Number:

Name:

Address:

Phone Number:

I, _____, give Francis P. O'Day, DDS, permission to release my medical records to the parties listed above. I understand that I may revoke this right at any time and agree to notify Francis P. O'Day, DDS in writing or in person, as to any changes that I wish to make regarding the above listed providers/family members/attorneys/etc.

_____ _____

Signature Date