Verification of Identity

Please provide us with the following information.

Name of patient whose information you are requesting: ________________________

Patient's date of birth: _______________________

The specific patient information that you are requesting:

Authorization to bring patient to appointments:

____

Your name:____

Address:____

City:_____________________________ State:__________ Zip:_______________

Describe your authority to access this information:

____

If you are a patient's personal rep resentative:

Relationship to Patient____

I certify that the above information is correct.

Signature: _______________________________________ Date:_____________________

Dental Staff: Describe documentation presented by the requester:

____