Authorization for Release of Confidential Information

I, ______________________________ D.O.B.____________ herby request and authorize the office of:__________________________ to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity to:

Arnold C. Gangwisch, D.M.D., P.A.
Michael S. Grandy, D.M.D.
Daniel G. Melzer, D.M.D.
Andrew Holtery, D.M.D.
John Miller, D.M.D., P.C.

☐ 530 Florida Avenue, Lynn Haven, FL 32444
Phone #: 850-271-2341 Fax #: 850-271-0679

☐ 22726 Panama City Beach Pkwy, Panama City Beach, FL 32413
Phone #: 850-271-0045 Fax #: 850-249-2029

Email: baysmiledocs@gmail.com

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records and all other related materials. I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed:______________________________ Date:____________________