ALLAN K. BERNSTEIN, D.D.S.

AUTHORIZATION TO RELEASE RECORDS

Please complete this form with the names and addresses of any and all health care providers you would like to have receive a consultation letter regarding your condition. These entries must be completed and initialed in order for the letter to be sent. This form will also authorize us to forward any records or discuss your future care with any health care provider listed.

I hereby authorize Allan K. Bernstein, D.D.S. to release or discuss my care with any of the (initialed) following health care providers, lien holders or their agencies.

____________________ _____ _____ ____________________

____________________ initial initial ____________________

____________________ ____________________

____________________ _____ _____ ____________________

____________________ initial initial ____________________

____________________ ____________________

____________________ ____________________

Patient signature (or Guardian) Date

INSURANCE/ATTORNEY INFORMATION

PART I

Primary Medical Insurance:
Insurance Carrier: ____________________
Policy Number: ____________________ Group Number: ____________________
Name of Insured: ____________________ Insured Date of Birth: ____________________
Insured Employer: ____________________
Insured Social Security Number: ____________________
Address of Insurance: ____________________
Phone Number of Insurance: ____________________

Secondary Medical Insurance:
Insurance Carrier: ____________________
Policy Number: ____________________ Group Number: ____________________
Name of Insured: ____________________ Insured Date of Birth: ____________________
Insured Employer: ____________________
Insured Social Security Number: ____________________
Address of Insurance: ____________________
Phone Number of Insurance: ____________________

____________________ ____________________

Patient Name Date