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