AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

I hereby request and authorize the release of all information, without limitations regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes medical-dental history, x-ray findings, diagnosis, prognosis and access to all hospital records and photocopies of the same.

I request that you release the above information to:

Dr. Michael Hasson, D.D.S., P.A.
1221 Floral Parkway, Suite 101
Wilmington, NC 28403
Phone: 910-793-0440
Fax: 910-793-0441

Patient's (or Legal Guardian's) Signature Date

Witness's Signature Date