Kent Burnett DDS

MEDICAL RELEASE FORM

1711 NW Grant Ave,
Corvallis, OR 97330
(541) 754-1668

420 Smith St
Harrisburg, OR 97446
(541) 995-8234

Please email completed form to: office@kentburnettdds.com

Authorization for Release of Medical Information

I hereby authorize the Physician listed below to release any information in my medical records relating to my diagnosis and treatment history for sleep disorders and sleep disordered breathing to:

Kent D. Burnett, D.D.S.
1711 NW Grant Ave
Corvallis, OR 97330
Telephone: 541-754-1668
Fax: 541-758-3010

to assist in the evaluation of my suitability for treatment of sleep disordered breathing. I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating physician or dentist. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims.

Physician's Name:_____

Address:_____

Phone:_____Fax:_____

Name:_____
Patient's Printed Full Name

Signature:_____Date:_____
Patient's Signature or Legal Guardian if patient is under 18