Date: ________________________________

I hereby authorize the doctors and staff of (**doctor/dental office**) __________________

____________________________________ to release records or knowledge concerning

dental health for (**patient**) ____ to:

Ferrara Family Dentistry LLC
F. Joseph Ferrara, DDS
301 Covington St.
Madisonville, LA 70447
contactus@ferraradental.com
fax: 985.792.0517

Signed (**patient or guardian**): ____

Printed name of **patient or guardian**: ____________________________________

Date of Birth of **patient**: ____

Kind Regards,

F. Joseph Ferrara, DDS