AUTHORIZATION for DISCLOSURE

	Dental Specialties of Saint Louis University	Dental Specialties of Saint Louis University 3320 Rutger Street St. Louis, MO 63104 314.977.8363

I authorize Dental Specialties of Saint Louis University to release the following information:

Patient's Name/Previous Names:

_____

_____

Birth Date Social Security Number Patient ID#

RECIPIENT (person or organization that will receive your information)

_____

(Doctor/Hospital/Attorney/Insurance Company/Self/etc.)

PURPOSE of DISCLOSURE