



ANDREW J. SPIRIDIGLOZZI, D.D.S.
10 North Park Place, Herkimer, NY 13350

Patient Authorization to Release Confidential Information

I _____ hereby request and authorize
Patient or Guardian

Previous Practice or Dentist Name

Street Address

City-State-Zip Code

to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

ANDREW J. SPIRIDIGLOZZI, D.D.S.
10 North Park Place, Herkimer, NY 13350
315-866-6250

Signed: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of minor child: _____

Relationship to child: Parent – Guardian – Other _____