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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ Birth Date _____

Address _____

I hereby authorize and request medical information from:

Covering the period from _____ to _____

Information Requested:

- _____ x-rays/photos/models
- _____ operative report
- _____ other (specify) _____
- _____ progress notes
- _____ pathology report

Release To: _____ Other (specify to whom) _____

Address: _____

Phone: _____

- _____ Randolph C. Robinson M.D., D.D.S.
- _____ Jeremy Z. Williams M.D.
- _____ Christopher G. Williams, M.D.

Signature of Patient or Authorized Representative _____ Date _____

Witness _____ Date _____

**Please note that this process can take up to 30 days.

9/21/2010