Authorization To Release Health Information

I, _____, hereby give authorization to have my records release to the office of Jessica L. Bishop DDS.

Please forward all permanent information and xrays to the following address:

Jessica L Bishop DDS, PA

6015 Farrington Road

Suite 102

Chapel Hill, NC 27517

laurie@jessicabishopdds.com

_____ _____

Signature Date

__ Entire Record __Billing/Insurance Records __Office Visit Notes

__Records specific to a certain condition/treatment:_____

__Clinical images (e.g., X-ray)

__Other (describe)_____

__Photos/Images:__ In Office __On Website __Other:_____