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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

**Please give this form to your previous dentist**

Patient's Name:

Date of Birth:

Address:

Social Security #:

I request and authorize

To release healthcare information of the patient named above to:

**Joshua H. Ehrlich, DMD PC  
3118 N. Sheffield Ave. Ste. 1N  
Chicago, IL 60657  
Phone: (773) 935-0300  
FAX: (773) 935-0302  
ehrllichdental@gmail.com**

Yes  No I authorize the release of any dental records, including xrays and tests to the person(s) listed above.

Patient Signature:

Date Signed: