M A T T H E W R Y A N , D. D. S.

DATE ______________________________

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RE: RELEASE OF PATIENT RECORD INFORMATION

NAME OF PATIENT ______________________________ DATE OF BIRTH ____________________

ADDRESS OF PATIENT ______________________________

Dear Doctor:

I am writing to request and authorize the release of the following information from my patient record: ______________________________

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covering the period of care from: ______________________________ to the most recent treatment date.

Please send this information directly to:

Matthew Ryan, D.D.S.
4350 Marconi Ave., Suite 300
Sacramento, CA 95821

The doctor or hospital releasing this authorized information is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

Thank you for your assistance.

Sincerely,

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signature of patient