J.D. Cooper, D.M.D.

3363 Tates Creek Rd., Suite 201, Lexington, KY 40502
Phone: 859-266-2570 Fax: 859-266-2570

# AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

J.D. Cooper, DMD

3363 Tates Creek Rd., Suite 201

Lexington, KY 40502

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ All healthcare information

☐ Other:

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.