Nicholas D. Doll, DMD, PC
909 E. Jackson St.
Macomb, IL 61455
(309)833-3500

RELEASE OF DENTAL INFORMATION

I ______________________________ hereby authorize __________________________________
to release my, or my family's, dental information, x-ray's, insurance information, and explanation, thereof, to Dr. Nicholas D. Doll, DMD, PC.

A photostat of this authorization will be valid as the original.

Name of Patient(s):	DOB of Patient(s):
______________________________	__________________________
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______________________________	__________________________
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______________________________	__________________________

Signature of patient or guardian: ____

Date: ____________________________