Dental Group at Reston Station

AUTHORIZATION TO RELEASE WRITTEN OR ORAL COMMUNICATION

Patient Name: _____

I, the undersigned, authorize Drs. Messina, Canal, Moawad and DiBenedetto to speak with the listed persons regarding my medical care. I understand that with my signature I am authorizing the release of written or oral communication to the listed persons and thereby release Drs. Messina, Canal, Moawad, DiBenedetto and their staff from all legal responsibility that may arise from the act hereby authorized.

Authorized Person	Relationship to Patient	Phone Number
Authorized Person	Relationship to Patient	Phone Number
Authorized Person	Relationship to Patient	Phone Number

Patient Signature _____ Date _____