Dental Group at Reston Station

AUTHORIZATION TO RELEASE WRITTEN OR ORAL COMMUNICATION

Patient name: _____

I, the undersigned, authorize Dr.'s Messina, Canal, Moawad, Back, Collins, and Colomo 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 Dr.'s Messina, Canal, Moawad, Back, Collins, and Colomo 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