Lake Jackson Oral and Maxillofacial Surgery
Richard C. Fugler, D.D.S., M.D.

Patient Name: _____ DOB: _____

I authorize information related to my diagnosis or treatment may be disclosed to the following person(s). Please check all that apply.

__ Spouse: _____

__ Parent: _____

__ Child: _____

__ Other: _____

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing.
I understand the revocation will not apply to information that has already been released in response to this authorization.

By signing this form, I understand that I am authorizing Lake Jackson Oral & Maxillofacial Surgery to release information as described above.

_____

Signature of Patient or Guardian Print Name Date

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