JOHN I. PARK, D.M.D., P.A.
400 AVE. K, S.E., SUITE 12
WINTER HAVEN, FL. 33880
(863)293-0023

AUTHORIZATION FOR THE RELEASE OF INFORMATION & CONSENT TO RECEIVE MAIL OR TELEPHONE MESSAGES

I hereby authorize the release of medical/dental information from John I. Park, D.M.D. for the purpose of:

Any request from My Insurance Company
Any Specialist I am referred to (Oral Surgeon, Periodontist, etc)
Other General Dentist

Should be sent to: _____

I understand that the information that may be released may include medical information that was provided by me. I hereby release Dr. John I. Park from all legal responsibility of liability that may arise from the action I have authorized above. I also give consent to receive mail or telephone messages from Dr. John I. Park.

Patient Name_____ Date_____

Signature _____ Date_____

Witness_____ Date_____