WILLIAM B. HAMEL III, D.D.S.

========================== *Comprehensive Dentistry* ==========================

210 Burlington Avenue, Clarendon Hills, IL 60514 (630) 323-0380

Fax (630) 323-0522 E-mail - DrWBH@hotmail.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ____ Date Of Birth: _____________________

I request and authorize ____ to

release healthcare information of the patient named above to:

W.B. Hamel III D.D.S. P.C.

210 W. Burlington Avenue

Clarendon Hills, IL 60514

E-Mail: DrWBH@hotmail.com

Fax: (630) 323-0522

This request applies to:

Healthcare information relating to the following treatment, condition, or dates: ______________________

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All healthcare information

Recent X-Rays (Bitewings and Full Mouth X-Rays)

Date of Last Prophy

Any History of Periodontal Maintenance (Dates and Nature of Maintenance)

Other: ____

Patient/Guardian Signature: ____ Date: _________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED