AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize Schleicher Dental Group and Associates permission to disclose medical information including but not limited to x-rays, dental charting, clinical notes, photographs, diagnostic casts and any other medical information necessary that may pertain to my dental health care.

I authorize this information to be released to my insurance carrier, Texas State Board of Dental Examiners, and any other third party administrator in order to facilitate and/or expedite claims and the delivery of my dental care.

Schleicher Dental Group
9099 Katy Fwy
Suite 180
Houston, Texas 77024

_________________ __________________
Patient Signature Date