DR. ROGERS
Implant, Esthetic and Comprehensive Reconstructions
*H. Winslow Rogers, DDS, MS, PA** **Board Certified Prosthodontist*

RELEASE OF PERSONAL HEALTH INFORMATION:

Date:_____

Patient name:_____

I, _____, give my permission for all of my or my dependant party's personal health information to be released to the following person/persons, to include written and verbal information.

Name/names:_____

Relationship to patient:_____

Signature:_____

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