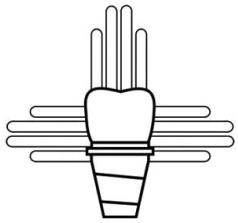

Authorization for Release of Medical Records and Information to Pino Periodontics, LLC.

Record Holder's Name: _____ Patient's Name: _____

Holder's Address: _____ Patient's Address: _____

_____ _____

Holder's Phone: _____ Patient's Phone: _____

I _____ hereby authorize release of any and all medical/dental records and information to:

Pino Periodontics, LLC
PO Box 94598
Albuquerque, NM 87199

Phone: 505-822-0565 Fax: 505-822-0571
Email: pinoperio@gmail.com

I authorize release of: (initial all that apply)

_____Patient Records

_____X-Rays and X-Ray Reports

_____Insurance Information

_____Other (Specify) _____

I authorize that a copy of this authorization shall be as valid as the original. This authorization will be valid until rescinded.

_____ _____

Today's Date Patient Signature

Updated 3/22/2016