**Marshpoint Dentistry**

**107 Charlotte Rd Suite H**

**Savannah, GA 31410**

**Authorization for Release of Information**

 **My signature below serves as authorization for Marshpoint Dentistry to release or receive medical information for the purpose of referral. A copy of this signature is valid as the original.**

 **To authorize the release of any medical information necessary to process this claim.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**