REFERRING PHYSICIAN DOCUMENT

Please note that any providers/family members/attorneys/etc. that you list below may receive a copy of your visit report(s) unless you specify that we not release your medical records to those listed below.

Referring Physician: ______________________________.

Address: ______________________________.

Phone Number: ______________________________.

Primary Care Physician: ______________________________.

Address: ______________________________.

Phone Number:______________________________.

Primary Care Dentist: ______________________________.

Address: ______________________________.

Phone Number:______________________________.

If there is anyone else you would like to receive reports regarding your care in this office please list below:

Name: ______________________________.

Address: ______________________________.

Phone Number:______________________________.

Name: ______________________________.

Address: ______________________________.

Phone Number:______________________________.

I, ____________________, give Francis P. O'Day, DDS, permission to release my medical records to the parties listed above. I understand that I may revoke this right at any time and agree to notify Francis P. O'Day, DDS in writing or in person, as to any changes that I wish to make regarding the above listed providers/family members/attorneys/etc.

Signature ______________________________ **Date** ____________________

1110 COLVIN BLVD TONAWANDA, NY 14223 PHONE: 716-565-0685