Authorization to Release Confidential Information

I _____ hereby request and authorize

_____ at _____

_____ to disclose and provide copies

of any and all clinical treatment records and information concerning my care to:

Cheryl Alper DMD 2 Lakeside Dr. Levittown, Pa. 19054. Tel 215-946-9469

Fax 215-946-3520. Email Dralper @comcast.net.

I expressly release from liability the above named person or entity and from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed_____ Date_____