



**JEFFREY M. BARLOW** DDS, PA  
SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS

## **AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize any dentist, orthodontist, physician,  
hospital, insurance company or organization to release  
any information pertaining to \_\_\_\_\_  
**Patient name**

In order that any following dental care may be continued  
without interruption.

**This authorization shall be valid as the original.**

\_\_\_\_\_  
**Signature of patient/guardian**

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