



## Authorization for Release of Information

This is to authorize John M. Bishop, DDS and Susan A. Takemoto, DDS at 4840 Riverbend Road, Suite 200, in Boulder, Colorado 80301 or any representative thereof, to receive copies of any and all dental records relating to me.

This authorization shall be valid for a period of one year from the date of execution.

A copy of this authorization may be utilized with the same effectiveness as an original.

Dated and signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

---

Patient Signature

---

Printed Name