LEFCOE, WEINSTEIN, SACHS & SCHIFF
FAMILY DENTISTRY, ORTHODONTICS
&
DENTISTRY FOR CHILDREN

AUTHORIZATION

I, _____, authorize Drs. Lefcoe, Weinstein, Sachs & Schiff to release information regarding my treatment, payment and/or healthcare operations to said authorized person(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature Date