

**AUTHORIZATION for DISCLOSURE**

**Dental Specialties  
of Saint Louis  
University**

Dental Specialties of  
Saint Louis University  
3320 Rutger Street  
St. Louis, MO 63104  
314.977.8363

I authorize Dental Specialties of Saint Louis University to release the following information:

**Patient's Name/Previous Names:**

\_\_\_\_\_

\_\_\_\_\_

Birth Date

Social Security Number

Patient ID#

**RECIPIENT (person or organization that will receive your information)**

\_\_\_\_\_

(Doctor/Hospital/Attorney/Insurance Company/Self/etc.)

## **PURPOSE of DISCLOSURE**