anesthesia for dentistry Mai-Phuong Huynh, DDS
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name_____
Patient Date of Birth_____

Parent/Guardian Name_____
Address_____
Telephone_____

I hereby authorize Mai-Phuong Huynh, DDS, FADSA, to obtain my child's medical records from his/her physician(s) for the purpose of providing general anesthesia for my child.

_____
Signature of Parent/Legal Guardian

_____
Date