

**John L. Little, D.D.S.
John P. Little, D.M.D., J.D.
Mary Russo, D.M.D.
804 Hwy 71
Sea Girt, NJ 08750
(732) 449-6564
(732) 449-8606 fax**

PROTECTED HEALTH INFORMATION RELEASE FOR:

Name_____

Date of Birth_____ (for identification purposes)

I hereby authorize and request you to release copies of my (my child's) x-rays to:

**Drs. John Little/Dr. Mary Russo
804 Highway 71
Sea Girt, NJ 08750**

You may also furnish the above with any necessary information needed for my (my child's) comprehensive dental treatment.

I understand that this consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient_____

Date_____

Or, Personal Representative_____

Date_____