

George F. Bork, DMD
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Hampton, NJ 08827
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AUTHORIZATION TO RELEASE REQUESTED INFORMATION

I hereby authorize that the office of Dr. George Bork be provided the following requested information.

Patient Name-

Patient Address-

Patient Date of Birth-

Signature of Patient/Parent/Guardian-

Date-

Information being requested-

If you have any additional questions please contact Dr. Bork's office at the above telephone number.

Thanking you in advance for your time and prompt attention to this request.