

Laurie A. Rosato, DMD  
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Concord, New Hampshire 03301  
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I, \_\_\_\_\_,  
with a date of birth of \_\_\_\_\_,  
hereby authorize the office of Laurie A. Rosato, DMD to release any  
information about my dental insurance, treatment recommended or  
completed, and any other information I have provided the office, to the  
following person(s) as needed:

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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Witness (Office Staff) \_\_\_\_\_ Date \_\_\_\_\_