Dr. O'Day
Goodbye TMJ

REFERRING PHYSICIAN DOCUMENT

Please note that any providers/family members/attorneys/etc. that you list below may receive a copy of your visit report(s) unless you specify that we not release your medical records to those listed below.

Referring Physician: _____.

Address: _____.

Phone Number: _____.

Primary Care Physician: _____.

Address: _____.

Phone Number: _____.

Primary Care Dentist: _____.

Address: _____.

Phone Number: _____.

If there is anyone else you would like to receive reports regarding your care in this office please list below:

Name: _____.

Address: _____.

Phone Number: _____.

Name: _____.

Address: _____.

Phone Number: _____.

I, _____, give Francis P. O'Day, DDS, permission to release my medical records to the parties listed above. I understand that I may revoke this right at any time and agree to notify Francis P. O'Day, DDS in writing or in person, as to any changes that I wish to make regarding the above listed providers/family members/attorneys/etc.

Signature _____ **Date** _____