Authorization for Release of Dental Records

☐ Individual Record:

Name:____Date of Birth:_____________________

☐ Family Records:

Name:____Date of Birth:_____________________

Name:____Date of Birth:_____________________

Address:________________________________

City:______________________State:_______

Phone:________________________________

RELEASE DENTAL RECORDS TO:

Name:____________________________________

Phone:____________________________________

EMAIL:____________________________________

Please release a copy of all my dental records, including but not limited to progress notes, periodontal charting and current radiographs.

BY MY SIGNATURE I AUTORIZE RELEASE OF DENTAL RECORDS

Patient/Parent or Guardian:_____________________________ Date:_______________

Patient/Parent or Guardian:_____________________________ Date:_______________