Record Release Form

I_______________________________ hereby authorize ____________________________

(office name) to release copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancelation date.

Signed ____ **Date**__________________

Signed____ **Date**__________________

(Parent, legal guardian, or POA of the patient, if patient is unable to sign for themselves)

Email Address to where records should be sent:

Familydentistry326@gmail.com