Authorization for Release of Dental Records

Patient's Name: ____

Patient's Date of Birth (DOB): ____________________________

Address: ____

City: _______________________ State: ____ Zip: ____________________

Additional family members to be included: ***(Only for patients under 18 years old)***

Name: _______________________________ DOB: ____________________

Name: _______________________________ DOB: ____________________

Name: _______________________________ DOB: ____________________\

I, (print patient or guardian name) ___________________________, hereby authorize the release of dental records or knowledge of my dental health to:

Dental Practice/ Patient: ____

Street Address: ____

City: _______________________ State: ____ Zip: ____________________

Practice Telephone Number: ________________________ Fax Number: _______________________

Dental Practice or Patient's Email Address: ____

Would you like us to delete all future appointments made for patients listed above: ___YES ___NO

Signed (Patient or guardian signature): _________________________________ Date: ___________

*** ***All patients 18 years old or older, will need a separate signed authorization form*** ***