Authorization for Release of Dental Records

Today's date: _____

Patient(s) Name and Date of Birth: _____

Requesting: Treatment Notes_____Perio Charting_____X-rays_____

Records to be: Emailed_____Mailed_____Picked up

Reason for Request: Quality of service____Cost____Seeing another dentist____Relocating

I Authorize the Request of my records from

Doctor's Name: _____

Phone #: _____

Address: _____

Email: _____

I Authorize the Release of my records to:

Doctor's Name: _____

Phone #: _____

Address: _____

Email: _____

Signature of Patient or Guardian: _____

Office Staff Initials:_____Date records were send/picked up_____

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