

AUTHORIZATION TO RELEASE RECORDS

To: _____

Patient: _____

Residing at: _____

is currently seeking dental care and/or consultation in my office. I understand that your office has his/her dental records. An authorization to release said records to my office has been completed by the patient as part of this form.

Dentist Signature

AUTHORIZATION

Kindly send a copy of my dental records, including X-rays, diagnostic reports, and correspondence related to my care to the doctor noted above. If there is a charge for the duplication of the records please notify me.

Signature

Witness

Date