DENT URGENT

DENTAL RECORDS RELEASE FORM

PATIENT NAME_____DATE OF B IRTH_____

I, _____, (PRINTED PATIENT NAME)

hereby authorize the doctor and staff of Dent Urgent to release records concerning my dental health. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records that pertain to my dental information.

Reason for release of records_____

Records to be released:

_____dental x-rays only

_____chart records only

_____both dental x-rays and chart records

Who are the records to be released to?

_____emailed to me, the patient at_____

_____mailed to me, the patient at_____

_____, _____ _____
CITY STATE ZIP

_____emailed to another dental office _____mailed to another dental office

OFFICE NAME_____

OFFICE ADDRESS_____
CITY_____STATE_____ZIP_____

OFFICE EMAIL ADDRESS_____
OFFICE PHONE NUMBER_____OFFICE FAX NUMBER_____

PATIENT SIGNATURE_____DATE_____