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AUTHORIZATION TO RELEASE DENTAL RECORDS

PLEASE COMPLETE ALL SECTIONS, DATE AND SIGN.

Patient Information:

Name of Patient: _____ Date of Birth:_____

Address: _____

City, State, Zip Code: _____ Phone: _____

North Asheville family dentistry may release the following information:

☐ Entire Record ☐ Financial Records ☐ Office Visit Notes ☐ Xrays

Entity or person who will receive the information:

Name: _____

Address:_____

City, State, Zip Code: _____ Phone: _____

Email Address: _____

This authorization will be in effect until the information has been forwarded or up to 90 days whichever comes first.

_____ _____

Signature of Patient or Personal Representative Date