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RECORDS RELEASE FORM

Patient Name: _____

Patient Address: _____

Patient City, State, Zip: _____

I hereby authorize the release of my dental records and x-rays, or copies of such, and request they be transferred to:

Name: _____

Address: _____

City, State, Zip: _____

_____
Print Name of Patient

_____
Patient's Signature (Parent's signature if patient is under 18 years old)

_____
Relationship to Patient (if minor)

.....

Office use only:
Date requested: _____ Patient to pick up: _____/_____
(date) (time)
Initials: _____