Authorization for the Release of Dental Records

I hereby authorize _____ to release the

information in the dental/medical record of _____(patient's name) to

_____
(name of dentist, physician, clinic or patient representative)

_____
(address)

_____

The purpose of this release of health information is:_____.

Information to be release: (Please check all that apply)

Current Bitewings _____ Date of last Hygiene visit _____

Current Panoramic_____ Perio Probings _____

Current Full Mouth _____ Other _____

This authorization is effective now and will remain in effect until_____ (no longer than one year). I understand that I may receive a copy of this authorization.

_____ _____
Signature Date

If not signed by the patient please indicate relationship to the patient:
____ parent of guardian of minor patient
____ guardian or conservator of an incompetent patient
____ beneficiary or personal representative of deceased patient

Dental Records can be sent electronically to info@prescottfamilydental.com or mailed

Prescott Family Dental
1015 Campbell Street
Prescott, WI 54022
715-262-3382
Fax number 715-262-3063

COPY TO BE PLACED IN THE PATIENT'S CHART