ARTISTICDENTAL
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BEAUTIFUL SMILES THROUGH EXCEPTIONAL DENTISTRY

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Acknowledgment and Authorization to Release Dental Records

I, _____, the patient and/or responsible party, am requesting release of my dental records to _____.

I am specifically requesting (example: xrays)_____, for (patient name) _____, (relationship)_____.

Signature:_____ Date:_____

_____

Patient:_____ Record Type:_____ Date of Record:_____

Patient:_____ Record Type:_____ Date of Record:_____

Patient:_____ Record Type:_____ Date of Record:_____

Patient:_____ Record Type:_____ Date of Record:_____

Patient:_____ Record Type:_____ Date of Record:_____

Patient:_____ Record Type:_____ Date of Record:_____

_____

Records forwarding address or email:

_____

_____

Staff member:_____ Date:_____

- This document to be scanned into the patients document center once signed and dated.