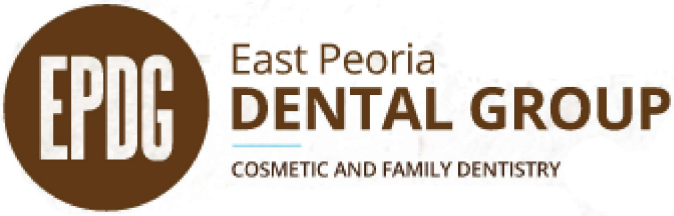


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# AUTHORIZATION TO RELEASE DENTAL RECORDS

**PATIENT NAME** | **DATE of BIRTH** | **PHONE NUMBER**

**ADDRESS** | **EMAIL**

**RECEIVING DENTAL OFFICE NAME**

**ADDRESS**

**EMAIL** | **PHONE #** | **FAX #**

**REQUESTED:** Copy of current dental x-rays

AUTHORIZATION: I request and authorize the dentist or health care provider to release the information specified below to the organization, agency or individual named on this request. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

NAME | SIGNATURE

RELATIONSHIP TO PATIENT | DATE