HAVASU DENTAL Center LLC

CONSENT TO RELEASE / REQUEST DENTAL RECORDS

I, _____ (patient name), do hereby consent and authorize _____ (previous dental office) to disclose to Carlos R. Ruiz, D.D.S. or Ilan H. Shamos, D.M.D., information in my record, including current and previous dental records from other practitioners, hospitals and / or other clinics, which are part of my record.

This information is strictly for the purpose of identification. I also consent to the release of dental records by Parker Dental Center in the event any additional information is needed by my insurance company or other providers.

Patient or Guardian Signature: _____
Print: _____
Relationship to Patient: _____
Patient's Date of Birth: _____
Today's Date: _____

Please send to:
Havasu Dental Center
Ilan H. Shamos, D.M.D. and Carlos R. Ruiz, D.D.S.
2872 Jamaica Blvd S
Lake Havasu City, AZ 86406
928.733.6199 office 800.540-8829fax
info@havasudentalcenter.com

Copies of the following are specifically requested:

- Progress Notes
- Letters/Reports to/from Specialists
- Periodontal Charting
- Radiographs
- Medical History Forms