



Riverside Family Dental, P.A.

Dr. Holly Hamilton, DMD

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AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than the terms specifically described below.

I, *(Patient Name)* _____,

DOB: ____/____/_____, hereby request and authorize

(doctor/practice) _____

(phone) _____ *(email)* _____

(address) _____

to release my dental records or information regarding my dental records to:

Riverside Family Dental, P.A., and Dr. Holly Hamilton

(Contact information above)

Purpose for which information is to be used:

____ Transfer of Records ____ Second Opinion

____ Other, please explain _____

OTHER CONDITIONS

A copy of this Authorization or my signature thereon *may*, or *may not* be used with the same effectiveness as an original:

Patient Name (Print)

Signature

Date

Person authorized to sign for patient

Relationship to patient

...MAKING A DIFFERENCE IN OUR PATIENTS' LIVES AND IN OUR COMMUNITY!