



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: ____/____/____ Address: _____,

hereby request and authorize

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

to release my dental records to (provide as much information as possible):

dentist/practice _____

address _____

e-mail _____

phone (____) _____ fax (____) _____

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!