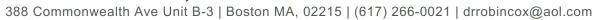
Robin R. Cox, DDS





Relationship to Patient

Authorization for Release of Dental Records

Patient Information

Date

	First N				Address		
SSN:				City		State	Zip Code
Birth Date: _			 	Home Number	Mobile Numbe	r	Work Number
Please send	records to: (Sel	ect Preferre	d Delivery Method, One	Only)			
Send	Attention To:		· · · · · · · · · · · · · · · · · · ·				
	□ To Fax num	nber:		(No Fee	e)		
	□ To Email Ad	ddress:		(No Fee	•)		
	□ Or Mail to: _	Name of Facility/ Person/ Doctor's Office		(Copy & Po		Camu ⁸ Daga	tore Foo
	_				_	Copy & Pos \$0.50/pag	_
			Street Address		·	first 100 p	
	-		City, State, Zip Code		•	\$0.25/pag excess of	
☐ Or Will Pick Up (Copy Fee)					•	Plus Posta	age
Purpose of I	Disclosure						
☐ Referral to	Specialist	☐ Disa	bility Determination	☐ Change of Do	ctor \square	Other (spe	ecify)
☐ Insurance		□ Perso	onal Copy	☐ Moving			
alcohol/drug l, the undersi such informa one designat	rmation. I ackrabuse, psychiagned, have reation herein coned above is for fany liability ar	nowledge a atric, Hepa ad the abo tained. I u bidden wi nd the und	orize the office of Drand hereby consent and hereby consent atitis, HIV/AIDS informates and authorize the inderstand that disclathout additional authorized will hold the Records." I understand	to such, that the remation and/or other of Dr. Robosure of this information on my parties office harmless,	eleased informer sensitive print in R. Cox, Donation to a part. This office for complying	mation received and the control of t	may containg information disclose for than the ased and his

Signature of Patient/Parent/Conservator/ Guardian