Riverside FAMILY DENTAL
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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.

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* ☐ *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!