PATIENT RELEASE FORM

DATE: ______________________________________

I ____________________________________ hereby authorize ___________________________________
(Patient Name in block letters) (Name of Current Dental Office)

to provide **DENTISTRY ON HURON** with copies of my dental records with respect to any dental care and treatment I have received. Kindly send the information via email to info@dentistryonhuron.com

Date of latest New Patient Exam: ____

Date of latest Hygiene Visit: ____

Date of latest Pan X ray: ____

Date of latest Bite Wing X Ray: ____

OTHER DETAILS : ____

THANK YOU

SIGNATURE OF PATIENT: ____

SIGNATURE OF PARENT/GUARDIAN: ____