Authorization For The Release of Dental Records

Dr. Katrina Eglian, D.M.D.
20921 Walnut Street
Red Bluff, CA 96080
(530) 527-7951
Fax (530) 527-7955

I hereby authorize _____ to release the information in the dental
(Other Dental Office)

record of _____ to: Dr. Katrina Eglian
(Patient) 20921 Walnut Street
Red Bluff, CA 96080

Patient Signature: _____ Date: _____

If not signed by the Patient, please indicate your name and relationship:

_____

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

COPY TO BE PLACED IN PATIENT'S CHART

If digital x-rays, Dexis
Please send to:
Drkatrina.eglian@gmail.com