Dental Records Release Form

Patient's name: _____
(Printed name of patient)

I hereby authorize the doctor and staff of Prestige Family and Cosmetic Dentistry to release records concerning my dental health to (select one):

____ 1. Myself

____ 2. Parent, guardian or agent of power of attorney

____ 3. Dental practice as indicated below:

Name of Practice: _____

E-mail Address: _____

Telephone Number: _____

Outstanding Balances:

I understand that my records will not be released until any outstanding balances on my account have been settled.

Authorization:

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire in 90 days.

Note: You may be asked to present proof of identification

_____
Signature of patient, parent, guardian or agent of power of attorney

_____
Date

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