RIVERSIDE DENTAL ARTS, PLLC
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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: _____/_____/_____, hereby request and authorize

(doctor/practice) _____

(phone) _____ *(email)* _____

(address) _____

to release my dental records or information regarding my dental records to:

Riverside Dental Arts, PLLC
(Contact information on letterhead)

Purpose for which information is to be used:

____ Transfer of Records ____ Second Opinion

____ Other, please explain _____

OTHER CONDITIONS

A copy of this Authorization or my signature thereon ☐ *may* *or* ☐ *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*

ELEVATE YOUR SMILE !