OAKWELL DENTAL CARE
Big City Convenience. Hometown Care.

DR. DYLAN CAREY & DR. ANTHONY SABINO
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main@oakwelldental.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT REQUESTS FOR TRANSFER OF DENTAL RECORDS

By signing this completed form, I authorize the transfer of the Dental Records for:

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

To the following Dentist on my behalf:

Dentist: Oakwell Dental Care

Address: 3301 Oakwell Court, San Antonio, Tx 78218

E-Mail: main@oakwelldental.com

Signature of Patient: Date:

_____ _____

Or Signature of Authorized Personal Representative Relationship to Patient

_____