Patient Authorization to Release Medical Records

Date:____________________

Practice/Doctor:____

Address:____

____

Phone:____

Fax:____

I ______________________________ ____________hereby request and authorize that my Medical Records, X-Rays, Ect. be released to:

Family Dental Care of Eufaula, P.C.
150 N. Orange Ave
Eufaula, Al. 36027
334-687-4613
334-687-4696 fax
eufaulafamilydental@gmail.com

These records include, but are not limited to: Patient information, medical and dental histories, exam records, radiographs, clinical photographs, treatment plans, treatment records and referral/consultation recommendations.

Patient/guardian:____

DOB:___________________

Additional Family Members Names & DOB:_________________________________

____

____

____

____