Request for Release of Dental Records

I, hereby, release all dental records including radiographs and daily treatment notes. I also release you from all legal responsibility or liability that may arise from this authorization.

Patient Name(s): _____

_____

Address: _____

_____

Signature: _____
(Patient/Guardian Authorized to Consent for Patient)

Date: _____

- ***Upon receipt of this signed release form, any and all scheduled appointments will be cancelled.***
- ***Dental Records will be released to Legal Guardian. Initial copy of records is at no charge. A fee will be assessed for additional copies.***
- ***Records will be transferred once all dental claims have been received and all balances are paid in full.***