CONSENT TO RELEASE / REQUEST DENTAL RECORDS

I, ________________________, do hereby consent and authorize ________________________ to disclose
(Patient name) ***(Previous Dental /Medical office)***

to P cf ke"P gy qtm'F gpvcn'Egpvgtu."cpf "j gkt"F qevqtu. information in my record, including current and previous dental and X-ray records from other practitioners, and/or clinics which are part of my"tgeqtf0

"Kco "tgs wguvkpi "vq"tgxkgy "c"eqr { "qh"cp{ "f gpvcn"tkmkpi "tgeqtf u."vj cv"P cf ke"P gy qtm'F gpvcn'Egpvgtu."o ckpvckpu0"

My date of birth is ________________
(Patient date of birth)

This information is strictly for the purpose of identification.

I also consent to the release of dental records by P cf ke"P gy qtm'F gpvcn'Egpvgtu in the event any additional information is needed by my insurance company or other providers.

Patient or guardian signature: ___________________________

Print: ______________________________

Relationship to patient: ___________________

Date: __________________________

Please send this to: """"P cf ke"P gy qtm'F gpvcn"Egpvgtu
AVVP/TGEQTFU
: 682"U'Gcuvgtp"Cxg0'Uwkvg"F
Ncu"Xgi cu."P X": ; 32:

If you have any questions, please call our office: *924+"46: /228:

Copies of the following records are specifically requested:

- ☐ Progress notes
- ☐ Letters/Reports to/from Specialist
- ☐ Periodontal Charting
- ☐ Radiographs
- ☐ Medical History Forms