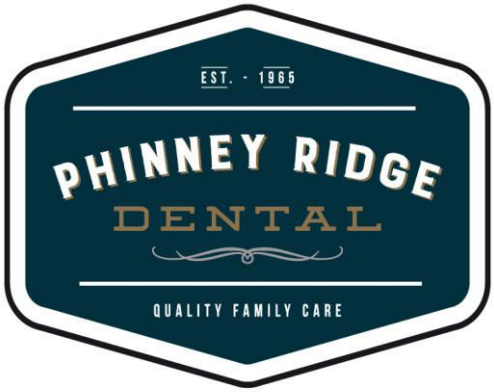

Authorization to Release Dental Records

Patient Name _____

Date of Birth _____

Address: _____

Phone: _____

I hereby authorize the release my dental records, including current radiographs, periodontal charting, treatment history, and any other relevant information to the following location:

Practice / Dentist Name _____

Phone Number _____

Email _____

By signing below, I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that my dental records will be sent to the provider listed above by mail or electronically. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

_____ _____

Signature **Date**

_____ _____

Name of Authorized Representative (If Applicable) *Relationship to Patient*