EAST BEND DENTAL

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AUTHORIZATION TO DISCLOSE DENTAL RECORDS

I hereby authorize ____ to release the information in

the dental records of ____to the office listed above.

Patient Name

Patient Information

Name: _____________________________________ **Date of Birth :** _______________________

Name: _____________________________________ **Date of Birth :** _______________________

Name: _____________________________________ **Date of Birth :** _______________________

By signing below I authorize the dental records released to include any x-ray if they exist. This authorization may be revoked at any time. Unless revoked, this consent will expire 180 days from the date of signing. I acknowledge that date to be released may include material that is protected by State and or Federal law which cannot be released without this consent.

Patient Signature ____

Legal Guardian Signature *(if applicable)* ____

Date: ____