

Arden Family Dentistry

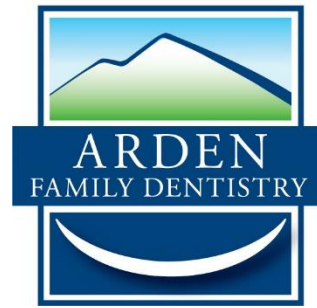
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✉ Email: office@ardenfamilydentistry.com



AUTHORIZATION TO RELEASE DENTAL RECORDS

PLEASE COMPLETE ALL SECTIONS, DATE AND SIGN.

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

I authorize **Arden Family Dentistry** to release the following information:

Entire Record

Financial Records

Office Visit Notes

Xrays

Entity or person who will receive the information:

Name: _____

Address: _____

City, State, Zip Code: _____ Phone: _____

Email Address and Fax#: _____

This authorization will be in effect until the information has been forwarded or up to 90 days whichever comes first.

Signature of Patient or Personal Representative

Date