Authorization to Provide Copies of Records and X-rays

I hereby authorize the disclosure of information contained in or related to my dental or medical records and x-rays or those records and x-rays of my dependent, listed below, which are in the possession of my dentist. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to provide copies of these records and x-rays to the person or persons designated below.

____________________	____________	____________________	____________
Patient Name (Print)	DOB (MMDDYY)	Patient Name (Print)	DOB (MMDDYY)
____________________	____________	____________________	____________
Patient Name (Print)	DOB (MMDDYY)	Patient Name (Print)	DOB (MMDDYY)
____________________	____________	____________________	____________
Patient Name (Print)	DOB (MMDDYY)	Patient Name (Print)	DOB (MMDDYY)

____ ______________

Responsible Party Signature Date

____ ______________

Responsible Party Signature Date

Please send records to:

Name of clinic/person(s): ____

Email address: ____

Caring dentistry, latest technology

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