dental professionals
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Patient Records Release

I give permission to Dental Professionals and its employees to release the dental records for,

Boxes outlined in red are required

Patient First Name | Patient Last Name | Date

Please release these records to:

- ☐ ***Dentist***
- ☐ ***Physician***
- ☐ ***Self***

Release to

Address

City | State | Zip

Phone | Fax

Reason for Release:

Physical Submission - Please print the form, sign below and drop off or mail the completed form to our office.

Signature (patient or guardian) | SELF — Relationship (if guardian) | Date

Initials | Patient Date of Birth | Last 4 digits of Soc. Sec. No. | email

Print Form