Patients Records Release

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

(Please Print) _____

Patient First Name | Patient Last Name | Date

Please release these records to:

- o Dentist
- o Physician
- o Self

_____

Release to

_____

Address

_____

City | State | Zip

_____

Phone | Fax | Email

Reason for Release:

_____

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