FAMILY DENTAL HEALTH
Family & Cosmetic Dentistry for All Ages

Authorization to Release Personal Health Information

I,____ hereby authorize the release of my dental records with respect to my dental care and treatment.

TO/ FROM: ____

DATE: ____

TO/ FROM: ____

PHONE/FAX: ____

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognoses and copies of any and all other records, including x-rays, which pertain to me.

I hereby release you from any and all legal responsibility or legal liability that may arise from the release of such information.

Date: ____

PATIENT NAME: ____

DOB: ____

SIGNATURE: __________________________ **DATE:** __________________________