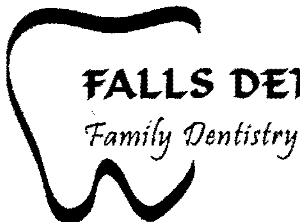

RECORDS RELEASE

DATE OF REQUEST__________

My permission is granted to **Dental Associates** to disclose to the noted Dr/clinic complete information concerning the medical findings and treatment of____

(Patients name)

From: ____________________

(Years)

Reason for leaving: ____

____

____

Release the above mentioned from any laws related to disclosure of confidential or privileged information. *Please note each record (per patient) is a cost of* ***$5.00*** *for duplication to be paid prior to the release of the Record.*

Signature ____.

Patients or person authorized to consent for patient

Address for records to be sent:________________________________

____

____

Date _______________

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