DOWNTOWN
Family Dental
of baraboo

RECORD RELEASE FORM

I, _____hereby authorize
(Patient's Name)

_____
(Dentist's Name)

to provide_____
(Party to whom the records will be sent)

with copies of my dental records with respect to any dental care and treatment.

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

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed_____
(Patient)

Signed_____
(Parent, Legal Guardian or Custodian)

Address_____
(Street)

_____
(City) (State) (Zip Code)

Date _____

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