Glacier Creek
DENTAL

AUTHORIZATION TO RELEASE DENTAL RECORDS

Today's Date:______________________

(Patient's Name) (Date of Birth)

Please choose one:

- ☐ Records requested for personal/referral use
- ☐ Seeing another provider, if so, please state why:______________________

Dental records to be sent to:

(Office Name) (Office Email Address)

(Office Phone Number) (Office Fax Number)

Requesting records from:

(Office Name) (Office Email Address)

(Office Phone Number) (Office Fax Number)

I request and authorize the above-named dental office to release the information specified above to the organization, agency or individual named on this request.

(Print Patient's Name) (Signature of Patient or Guardian)

(Date)