The Dental Studio

F R E D E R I C K

Authorization for the Release of Dental Records

I hereby authorize The Dental Studio of Frederick to release the information in the dental record of ______________________________________ (patient's name) to the following entity:

Name: ____

*May be dentist, physician, clinic or patient's representative.

Address: ____

____

Email Address: ____

Phone: ____

Fax: ____

Any and all information may be released except as specifically provided below:

____

____

____

Patient Name: ____

Patient/Guardian Signature: ____

Date: ____

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