

## DENTAL RECORDS RELEASE FORM

Patient Information		
<b>First Name</b>	<b>Last Name</b>	<b>Date of Birth</b>

Records Released	
<b>Dental Provider/Practice Name</b>	
<b>Description of Records Released</b>	
<b>Purpose for Release</b>	
<b>Expiration Date of Authorization</b>	

Records Recipient			
<b>Recipient Name</b>			
<b>Street Address</b>			
<b>City</b>			
<b>State</b>			
<b>Zip Code</b>			

I understand that by signing this form, I am granting permission for the release of the specified dental records. This authorization expires on the date mentioned above, after which the dental provider is no longer authorized to disclose my records.

I acknowledge that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization.

**Signature Date:**

**Signature:**