3023 Eastland Boulevard

Suite #112

Clearwater, FL 33761

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient: _____

DOB: _____

Address: _____

THIS WILL AUTHORIZE RELEASE OF DENTAL RECORDS FROM:

Doctor: _____

Address: _____

Phone: _____Fax:_____E-mail_____

I request and authorize the above-names doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

_____Copy of dental x-rays
_____Other _____

*** If e-mailing x-rays to Northwood Dental, please use e-mail address:**

reception@northwood-dental.com

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

_____Transfer of Records _____Second opinion

_____Other, please explain _____

_____ _____
Date Signature of Patient or Parent