P.O. Box 787 / 246 Division St.
Leavenworth, WA 98826

P: (509) 548-5841 / F: (509) 548-1064
office@schiefelbeindmd.com

AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

Patient Name (please print): ____

Date of Birth: ______________________________

Address: ____

City/State/Zip Code: ____

Telephone Number: ____

I hereby authorize __________________________________ to release a copy of my dental records to:

Dentist/Provider: ____

Address: ____

City/State/Zip Code: ____

Telephone Number: ____

Email: ____

*Please send the specific information (specify dates of service):________________________________

____

____

*Reason for release:

____

____

I hereby release _________________________________ and its staff from all legal responsibilities that may arise from the act here authorized. To be valid, this authorization must be dated within 90 (ninety) days of the request for the information and can be revoked at any time.

Patient signature ____ Date _________________

Parent/ Legal Guardian ____ Date _________________

For Office use only:

Records sent by_____________________________ Signature _________________________________

Date sent __________________________________