AUTHORIZATION TO RELEASE DENTAL RECORDS

THE EXECUTION OF THIS FORM DOES NOT AUTHORIZE THE RELEASE OF INFORMATION OTHER THAN THAT SPECIFICALLY DESCRIBED BELOW.

PATIENT NAME:____

PATIENT DOB: ___/___/_____

RELEASE TO: (PLEASE PROVIDE NAME AND ADDRESS)

Argyle Family Dental
8120 S. Holly St. #208
Centennial, CO 80122
Phone: 303-770-2254
Fax: 303-770-2285
office@argylefamilydental.com

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual on this request.

Previous Dentist: ____

INFORMATION REQUESTED (please check)

____ **Copy of dental x-rays**
____ Referral slip
____ Treatment plan

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED: Transfer of records

____
Patient Name (Print)

____
Patient Signature Date