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 *

First Name Last Name

RELEASE TO: (PLEASE PROVIDE NAME AND ADDRESS)

Name

Address

Street Address

City State / Province

Postal / Zip Code

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) *

First Name Last Name

Date *

Month Day Year

Signature