Release of Records Authorization Form

CANNON FAMILY DENTISTRY

Patient Information

Patient First Name | MI | Patient Last Name | Patient Date of Birth

Informed Consent Information

The purpose of this document is to provide written information regarding the risks, benefits, and alternatives to the procedure named above. This material serves as a supplement to the discussion you have with _____. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask _____ prior to signing the consent form.

Release from Another Provider

Previous Dentist's Name/Practice Name

Previous Dentist's Address

Previous Dentist's Phone Number

Previous Dentist's Email Address

PLEASE SEND A COPY OF:

- [ ] All my dental records
- [ ] Dental x-rays
- [ ] Other

Release to Another Provider

New Dentist's Name/Practice Name

New Dentist's Address

New Dentist's Phone Number

New Dentist's Email Address

PLEASE SEND A COPY OF:

- [ ] All my dental records
- [ ] Dental x-rays
- [ ] Other

Consent

By signing below, I consent for my dental treatment records and/or x-rays to be transferred by email to _____.

Practice Name:

Practice Address:

Practice Phone number:

Patient's Signature	Date	Doctor's Signature	Date