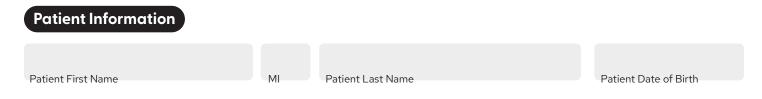
Release of Records Authorization Form





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