2466 Hwy 6&50 Unit #3
Grand Junction, CO 81505
(970)639-9551

Patient Authority to Release Dental Records

I, _____ hereby authorize Dr._____
(previous dentist) of _____
To release my dental records or copies thereof (including radiographs and photographs where applicable) and those of my following dependents:

_____
_____
_____

***And to provide such records to*:**
Dentist Name: _____
Address: _____
Phone Number: _____
Fax number: _____
E-mail: _____

I understand that the release of these confidential records is at the discretion of the treatment dentist.

Signature: _____
Name (in full): _____
Address: _____
_____
_____

Telephone: _____