

Release of Records

I _____, understand that by signing this form, I am giving my consent for my dental records, health information and x-rays to be released to _____, for the purpose of carrying out treatment and/or healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____