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DENTAL RECORDS RELEASE

Patient Information:

NAME:____ **Date of Birth:**_________________

ADDRESS:___________________________________**City/St/Zip**_____________________________

HOME PHONE:__________________**CELL PHONE**_________________**WK PHONE**_______________

Purpose of Release: Please indicate the purpose for releasing the information:

____

RELEASE TO DENTIST/PRACTICE NAME____

CITY/STATE_____________________________________**PHONE**_____________________________

STATEMENT OF AUTHORIZATION:
I HEREBY GIVE PERMISSION TO LING FAMILY DENTISTRY, PA TO RELEASE DENTAL INFORMATION THEY SEEM ESSENTIAL REGARDING MY DENTAL TREATMENT.
I AM SEEKINGDENTAL CARE ELSEWHERE FOR THE REASON LISTED ABOVE, AND AUTHORIZE MY PATIENT STATUS TO BECOME INACTIVATED AT THE CLINIC.

PATIENT SIGNATURE/PARENT of MINOR________________________________**DATE**____________

TO BE FILLED OUT IF SOMEONE OTHER THAN YOURSELF IS PICKING UP RECORDS

I_______________________**AUTHORIZE LING FAMILY DENTISTRY TO RELINQUISH MY RECORDS TO**_______________________**(With proof of identification)**

Patient signature____**DATE**_______________