CENTER SQUARE
FAMILY DENTAL

Release of Dental Records

Patient Name: ______________________Date of Birth: ____________________

Family Member(s) Name / Date of Birth: _________________________________

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❑ **<u>Request For Record(s)</u>** ❑ **<u>Release Of Record(s)</u>**

I authorize all information, records, x-rays, charts, test results, laboratory and/or clinical findings or evaluations concerning my Dental / Medical history: includes your findings, diagnosis, treatment, evaluations, opinions and prognosis related to treatment.

This authorization shall constitute valid authorization for parties noted to inspect all such records to copy or request and receive copies thereof from you, and for you to freely discuss and comment on my medical history and treatment.

This authorization shall be valid and binding for three years unless specifically revoked in writing. A copy of this original authorization shall be sufficient and as good as the original.

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Patient / Guardian's Signature **Date**