DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____\ _____ \ _____

PERSON EITHER AUTHORIZING OR REQUESTING RELEASE OF INFORMATION:

NAME: _____

RELATIONSHIP TO PATIENT: □ MOTHER □ FATHER □ GUARDIAN □ OTHER

PLEASE CHECK APPROPRAITE BOX:

□ I AM REQUESTING DENTAL RECORDS BE SENT TO:

AURORA CHILDREN'S DENTISTRY
3340 PROVIDENCE DRIVE SUITE 552, ANCHORAGE, AK 99508
FRONTDESK@AURORACHILDREN.COM
PHONE: 907-336-1234 FAX: 907-336-4321

□ I AUTHORIZE AURORA CHILDREN'S DENTISTRY TO DISCLOSE TO: □ SELF □ DENTAL PROVIDER □OTHER

NAME OF SELF/ DENTAL PROVIDER /OTHER:

_____

PHONE #: _____ FAX #: _____

EMAIL: _____

INFORMATION TO BE DISCLOSED: □ XRAYS □ TREATMENT PLAN □ CHART NOTES

_____ _____

SIGNITURE OF PATIENT DATE
□Parent/ Legal guardian