Boise
FAMILY DENTAL
Care PLLC

Authorization to Release Dental Records

This form is to authorize the release of medical records including x-rays and treatment records.

Patient Name:_____

Date of Birth:_____

Address:_____

Phone Number:_____

Current Dentist:_____

Address:_____

Phone Number:_____

Fax Number:_____

Please send Records to: *EMAIL IS PREFERRED*

Name or Office:_____

Address:_____

Phone Number:_____

Fax Number:_____

Email:_____

I hereby consent to the release of all dental records including x-rays obtained through my entire course of dental care and diagnosis and treatment from any dentist who has provided care for me.

SIGNED_____ DATE_____