



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 _____