DENTAL RECORDS RELEASE FORM

Patient Information		
First Name	**Last Name**	**Date of Birth**

Records Released	
Dental Provider/Practice Name	
Description of Records Released	
Purpose for Release	
Expiration Date of Authorization	

Records Recipient			
Recipient Name			
Street Address	**City**	**State**	**Zip Code**

I understand that by signing this form, I am granting permission for the release of the specified dental records. This authorization expires on the date mentioned above, after which the dental provider is no longer authorized to disclose my records.

I acknowledge that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization.

Signature Date: **Signature:**