



3023 Eastland Boulevard

Suite #112

Clearwater, FL 33761

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient: _____

DOB: _____

Address: _____

THIS WILL AUTHORIZE RELEASE OF DENTAL RECORDS FROM:

Doctor: _____

Address: _____

Phone: _____ Fax: _____ E-mail _____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED:

_____ Copy of dental x-rays

_____ Other _____

*** If e-mailing x-rays to Northwood Dental, please use e-mail address:**

reception@northwood-dental.com

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED

_____ Transfer of Records

_____ Second opinion

_____ Other, please explain _____

Date

Signature of Patient or Parent