Bright Smiles Dental LLC

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AUTHORIZATION TO RELEASE DENTAL RECORDS

Name: _____ Date of birth: ___/___/___

Additional Family members (under age) to be included:

Name: _____ Date of birth: ___/___/___

Name: _____ Date of birth: ___/___/___

Name: _____ Date of birth: ___/___/___

I AUTHORIZE BRIGHT SMILES DENTAL TO RELEASE or RECEIVE THE INFORMATION SPECIFIED BELOW TO THE ORGANIZATION, AGENCY OR INDIVIDUAL NAMED ON THIS REQUEST.

PERSON(S) AUTHORIZED TO RECEIVE or RELEASE THE INFORMATION:

Name of person or institution_____

Address: _____

City/State/Zip _____

Phone#: _____ Email: _____

INFORMATION TO BE RELEASED:

X-rays Chart

_____ _____

SIGNATURE OF PATIENT/PARENT **DATE**