

**Authorization to Release Medical & Dental Records**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize ***Diane Jenkins Periodontics*** to release copies of my dental/medical records with respect to any dental/medical care and

treatment to :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(Office receiving records)

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and copies of any and all other records, including x-rays, that pertain to me.

I hereby release ***Diane Jenkins Periodontics*** from any and all legal responsibility or legal liability that may arise from the release of such information.

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print)

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Legal Guardian)

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(For Office Use Only)

**BWX Date Taken:\_\_\_\_\_\_\_\_\_\_\_\_**

**Pano Date Taken:\_\_\_\_\_\_\_\_\_\_\_\_**

**FMX Date Taken:\_\_\_\_\_\_\_\_\_\_\_\_**

**PA’s Date Taken:\_\_\_\_\_\_\_\_\_\_\_\_**