Diane Jenkins D.M.D., M.S.
PERIODONTICS AND IMPLANTOLOGY
DISCOVER YOUR BEST ORAL HEALTH

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:_____

(For Office Use Only)

BWX **Date Taken:**_____

Pano **Date Taken:**_____

FMX **Date Taken:**_____

PA's **Date Taken:**_____