STEADFAST
FAMILY DENTAL

Record Release Form

I, _____
(Patient Name)

Hereby authorize

_____
(Provider who is releasing the records)

To provide to

_____
(Name of the Provider Receiving the records)

With copies of my dental records with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me. This consent is effective until such date in which I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signature of Patient/Guardian/or Healthcare Proxy if patient is unable to sign themselves

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*Date:*_____

Mailing Address to which the records should be sent to:
_____
_____
_____

Email address to which the records should be sent to: frontdesk@steadfastfamilydental.com