Authorization to Release Dental Records

Please complete this form if you are changing dental practices and either mail it to our office at 712 Lee St, Des Plaines, IL 60016 or fax it to 847-296-8113. Requests will usually be processed in five (5) business days.

____
Today's Date

____ ____________________
Patient Name | Date of Birth

____
Home Address

____________________________________ __________ ______________
City | State | Zip

I authorize the release of information, including medical and dental prognosis, and dental x-rays to the following party:

____
Name

____
Address

____________________________________ __________ ______________
City | State | Zip

____________________________________ ________________________
Phone | Fax

____
Email Address

____ ____________________
Patient or Responsible Parent/Guardian Signature | Date