Christopher Drew, DDS
Michael G. Smith, DMD

AUTHORIZATION/NOTIFICATION TO RELEASE DENTAL RECORDS

Patient Name: _____

Birth Date: _____ Daytime Phone: _____

I hereby authorize Christopher Drew, DDS to release dental record information concerning the above named patient to:

Recipient's Name: _____

Address: _____

Daytime Phone: _____

Copies of Dental Records _____ Copies of Dental X-Rays _____

I authorize the release of photocopies of the following dental records and/or diagnostic images in the possession of Christopher Drew, DDS, its employees, and/or agents. I hereby release you, your dentists, and your employees from any and all liability for fulfilling the authorization request for release of dental information.

The undersigned and listed patient has hereby requested the transfer of said records.

_____ _____

Patient/Guardian Signature Date

_____

Relationship to Patient