Privacy Practices Acknowledgement

I have read and understand the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____

Birthdate_____

Signature_____

Date_____

Release of Records

Please release records for :_____

_____

Authorize release to :_____

_____

I hereby authorize and request the release of dental records, including x-rays, perio charting, and any information of value in treating the patient.

Signed:_____**Date:**_____