Authorization To Release Dental Records

Patient Name: _____

Date of birth: _____

Address: _____

City, State, Zip: _____

I hereby authorize _____to release, disclose, and deliver necessary dental information, radiographs, perio-charting, or recorded treatment to

Christensen Dental, 10521 Jeffreys Street #200, Henderson, NV 89052,

Phone 702-337-2121 Fax:702-337-1616 Email : info@christensendental.com

Authorized Recipient(s) _____

_____ _____

Patient signature (or guardian if a minor). Date

Previous dental office

Phone: _____

Fax: _____

Email: _____