Fayetteville Dental Studio

CONSENT TO RELEASE OF DENTAL TREATMENT RECORDS

Patient Information:

Name: _____

DOB: _____

I, hereby certify that I am: (check one)

_____ The Patient

_____ The parent of the patient, who is under age 18

I hereby request and authorize the office of Fayetteville Dental Studio, Dr. Gurung to release and obtain my dental treatment records and x-rays as follows: (Check one)

_____ to me (I will pick them up)

_____ to me at the following address: _____

_____ to the following name person, who will pick up the records for me: _____

_____ to the following named dental office: _____

_____ Date: _____

Signature of Patient or Patients Legal Guardian

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