Medical / Dental Record Information Release

Section 1: Personal Information

Name:_____ Date of Birth:_____

SSN:_____ Daytime Phone #:_____

Section 2: Release Information

Today's Date:_____ Date Records needed:_____

Information to be released:

_____Current X-Ray

_____Other_____

Medical /Dental records are to be: ____**Picked up** _____**Mailed to Individual listed below**

Name of Individual to receive records:_____

Address of Recipient_____

Or Email Address: office@monroefamilydentistrync.com

Section3: Authorization for Release: PLEASE SIGN BELOW

I request that_____release my medical/ dental records with the stipulation that the released information be confidential. This information should be forwarded to the location provided above. I understand that this authorization is revocable unless action has already been taken and that unless revokes it is valid for 90 days.

_____ Date_____

For office use only:

Date records mailed/released:_____ Initials_____