



## 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:** [monroefamilydentistry1@gmail.com](mailto:monroefamilydentistry1@gmail.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 \_\_\_\_\_