



Dr. Bart A. Samuelson, P.C.

Dr. Jeri L. Scranton, P.C.

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient: _____

Birth Date: _____ Previous name (if any): _____

Present Address: _____

THIS WILL AUTHORIZE RELEASE OF DENTAL RECORDS FROM:

Doctor: _____

Address: _____ City/St/Zip: _____

SEND INFORMATION TO:

Name: _____

Address: _____ City/St/Zip: _____

A photocopy of this authorization shall be considered as valid as the original.

Date

Signature of Patient or Parent

Witness

Relationship to patient if signed by parent