



**HOLDEN DENTAL CARE**

**DENTAL RECORDS RELEASE FORM**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby authorize that my dental records be released to:

Dr. \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone # \_\_\_\_\_

Email \_\_\_\_\_

FMX \_\_\_ DATE \_\_\_\_\_

BWX \_\_\_ DATE \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date