STRAIT SMILES
FAMILY DENTISTRY

Authorization for the Release of Dental Records

I hereby authorize Strait Smiles Dental Office to release the dental records for

Patient's name:
_____

to

Name of dentist, physician, clinic, or patient's representative:

_____

Street Address: _____

City:_____ State: _____ Zip Code: _____

This authorization is effective for one year.

Signature: _____ Date: _____

If not signed by the patient please indicate relationship:

__ Parent or guardian of minor patient
__ Guardian or conservator of an incompetent patient
__ Beneficiary or personal representative of deceased patient

Revised 2017