KEMPEINEN
Dentistry, P.C.

I HEREBY AUTHORIZE:

_____
Name of Dentist

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

TO RELEASE MY DENTAL RECORDS TO:

_____
Name of Dentist

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

_____
Email Address

INFORMATION REGARDING:

_____

_____

This authorization shall be valid for one year unless otherwise stated or revoked through written notice to Kempeinen Dentistry, P.C

_____
SIGNATURE OF PATIENT DATE SIGNED

_____
SIGNATURE OF AUTHORIZED PERSON DATE SIGNED

1103 S. Cedar St., Suite 100 Mason, MI 48854 (517) 676-5900