RECORDS RELEASE INFORMATION

I hereby authorize and request Rodney D. McDonald, DDS to release any pertinent records concerning my dental care and/or treatment to:

Name:____

Address:____

City:_______________State:_________________Zip Code:_______

I understand that the law in the state of Indiana asks that all dentists keep records of dental care for at least five years; therefore we will release copies of any current radiographs.

The copying process will take approximately 10 to 15 days to complete.

Signature:__________________________________Date:_________________

Witness:____________________________________Date:_________________