Kailua Dental Arts
970 N. Kalaheo Avenue Suite A-305
Kailua, HI 96734
tel: 808-254-5454
fax: 808-254-5427

RECORDS RELEASE

This is to certify that I give permission to Kailua Dental Arts to release my/our dental x-rays and records to:

Name: _____
Address: _____
Phone: _____
email: _____

Patient Names (print): _____
_____
_____
_____
_____

Signature: _____
Relationship to patient: _____

AGREEMENT: By signing this Electronic Signature Acknowledgment Form, I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.