

Authorization For Release of Dental Records

NAME OF PATIENT _____

DOB _____

ADDRESS OF PATIENT _____

Street Address

City

State

Zip

**I HEREBY AUTHORIZE Rahway Dental Group, TO RELEASE
MY MEDICAL AND DENTAL INFORMATION TO:**

Name _____

Address _____

Phone _____

Fax _____

The Information To Be Disclosed Is:

_____ Medical/dental History

_____ Treatment/progress Notes

_____ Dental X-rays

_____ Other

Signature of Patient _____ Date _____

{Parent or Guardian if patient is a minor}

Printed Name of person signing on behalf of patient _____