



D O W N T O W N

**Family Dental**  
*of baraboo*

## RECORD RELEASE FORM

I, \_\_\_\_\_ hereby authorize  
(Patient's Name)

\_\_\_\_\_  
(Dentist's Name)

to provide \_\_\_\_\_  
(Party to whom the records will be sent)

with copies of my dental records with respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including x-rays, which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed \_\_\_\_\_  
(Patient)

Signed \_\_\_\_\_  
(Parent, Legal Guardian or Custodian)

Address \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip Code)

Date \_\_\_\_\_

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