HURON COAST DENTAL
508 W Lake Street
P.O. Box 387
Tawas City, MI 48764-0387
989.362.6159
Fax 989.362.6798
Email: carried@johnllesneskidds.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby release the Doctor's and their employees from all provisions of the law prohibiting the dental office from disclosing any dental records, including x-ray files and reports of:

NAME: DOB:

I authorize release of my information from/to the following offices:

From: To:

The reason for this disclosure (circle one):

Transfer of care Out of network Moving out of the area

This release and authorization will expires without notice six (6) months from the date listed below. You must be at least 18 years or older to request your records.

Name/s (printed):

Signature Date

Witness (Office employee only) Date