ASSOCIATES IN PERIODONTICS
periodontics and dental implants

1120 East Elizabeth Street, G4
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(970) 221-5050

RELEASE OF RECORDS

This notice allows Associates in Periodontics to release dental and/or financial information to a named relative or contact that may call on your behalf, requesting this information.

I, _____ hereby authorize Associates in Periodontics to disclose/ release information for ☐ **dental** ☐ **financial** or ☐ **both**, pertaining to me, to the following persons:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

May we keep your referring dentist informed of the treatment you were sent to us for? ☐ Yes ☐ No

Primary dentist or other physician you would like to release records to:

1. _____ Phone number: _____
2. _____ Phone number: _____
3. _____ Phone number: _____
4. _____ Phone number: _____

Patient's Full Name: _____ Date of Birth: _____ / _____ / _____
(*Please print full name - first name, middle name and last name*) *mm dd yy*

Signature of Patient: _____ Date: _____ / _____ / _____
mm dd yy

Parent/ Guardian's Name: _____

Signature of Parent/ Guardian: _____ Date: _____ / _____ / _____
mm dd yy