Young Smiles Family Dentistry

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AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name_____ Date of Birth_____

Address_____

Email Address_____ Phone Number_____

Disclosed Information: (check all items to be released)

☐ X-Rays ☐ Medication Record ☐ Entire Record ☐ Other:_____

Information to be provided To:

Name of Person or Institution_____

Address City/State/Zip Code _____

Telephone number_____ Fax number _____

Email_____

Authorization:

I hereby authorize **Young Smiles Family Dentistry**, its agents and its employees to release protected health information described above.

By signing this form, I understand that I am authorizing Young Smiles Family Dentistry to release information as described above.

Patient Signature:_____ Date:_____

Print Name:_____