GORHAM FAMILY DENTISTRY, P.A.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name_____ D.O.B_____

Address_____

_____

I Authorize: _____

_____

_____

To Disclose To:_____

_____

_____

_____Current Dental Records

_____Other_____

This consent authorizes the above information to be sent in either traditional or digital format by postal delivery, fax or email. This consent will expire 60 days from the date signed unless otherwise specified by me in writing. I understand that I cannot withdraw already disseminated information.

Signed:_____ Date:_____

Relationship to patient if other than self:_____