Huron Coast Dental
508 W. Lake St., P.O. Box 387
Tawas City, MI 48764-0387
989-362-6159
Fax 989-362-6798
carried@johnllesneskidds.com

AUTHORIZATION TO RELEASE DENTAL RECORDS INFORMATION

I hereby release Dr._____and his/her employees from all provisions of the law prohibiting his/her dental office from disclosing any dental records, including x-ray files and reports of:

Pt's Name: DOB:

Name of dental office getting records from:
Phone # and Fax #:

I authorize release of my information to: Huron Coast Dental

This release and authorization will expire without notice six months after the date listed below. You must be at least 18 yrs or older to request your records.

Name:(printed)_____

Signature:_____

Witness:_____

Date:_____

"This release is for a patient coming into our office"