Authorization to Release Dental Information

Please forward copies of all my dental records, radio graphs, medication sheets, interpretations of tests, progress notes, billing/account ledger and any other information pertaining to my dental treatment.

Patient's Name: ______________________________

DOB: ____________________

To: Fenwick Dental

Address: 13901 Coastal Highway, Suite 4

Ocean City, MD 21842

Telephone Number: 410.250.1559

Email: info@fenwickdental.com

From (former dentist): ______________________________

Address: ______________________________

City, State, Zip Code: ______________________________

Telephone Number: ______________________________

Fax Number: ______________________________

I request and authorize the above named doctor to release the information to the organization, agency, or individual named in this request. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. A copy of this authorization or my signature thereon shall be used with the same effectiveness as the original.

Patient Name (printed): ______________________________

Patient Signature: ____________________ Date: ______________

Witness: ____________________ Date: ______________