508 w. Lake St. P.O. Box 387
Tawas City, MI 48764
P: 989-362-6159
F: 989-362-6798
Email: Carried@JohnLLesneskidds.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby release the Doctor's and their employees from all provisions of the law prohibiting the dental office from disclosing any dental records, including x-ray files and reports of:

Name: **DOB:**

I authorize the release of my information from/to the following offices:

From: **To:**

The reason for this disclosure (circle one):

Transfer of care Out of network Moving out of the area

Other:

This release and authorization will expire without notice six (6) months from the date listed below. You must be at least 18 years old to request your records.

_____
Name(s) printed:

_____ _____
Signature(s): Date:

_____ _____
Witness (Office employee only): Date: