Authorization to Release Dental Records

PATIENT INFORMATION:

Family Members/ Birth Date

_____

_____

_____

_____

_____

SEND RECORDS TO:

Dr. Stuart Coe, DDS

11775 Pointe Place Suite 101

Roswell, GA 30076

INFORMATION TO BE DISCLOSED:

☐ Exam & Treatment Notes Date:

☐ Radiographs (X-rays) Date:

SEND BY:

☐ Send via e-mail: Smilesbydrcoe@gmail.com

☐ FAX: 770-475-8666

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

Print Name (Patient/Guardian):_____Date:_____

Signature (Patient/Guardian): _____ Date:_____