Permission to release records to Eastview Family Dentistry

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Best Contact Phone Number: _____

I hereby authorize

Dentist's Name: _____

Address: _____

Phone: _____

Fax: _____

to release my dental records to

Eastview Family Dentistry
870 Slaughter Road
Madison, AL 35758
256-325-9393
receptionist@eastviewfamilydentistry.com

I understand that I am signing this authorization freely; that I may revoke this authorization at any time by providing written notice to the practice: that I may not revoke this authorization if the practice has already taken action utilizing this authorization; that the information disclosed in this authorization may be subject to redisclosure by the practice and no longer protected by federal law; and I understand the intent and use of this authorization.

Signature of Patient or Parent/Guardian: _____

Date: _____

For Office Use: Faxed to other dental office at
Date: _____ Time: _____