Alan W. Haussermann d.d.s ❐ 919 west kirby avenue ❐ champaign, illinois 61821 ❐ 217-359-2500
general destistry

Records Release Form

Date: _____

I hereby authorize Alan W. Haussermann, D.D.S. to release copies of my dental records and radiographs to:

Office Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Email address(es) to send records (records can be emailed to your new dental office and/or your personal email address):

_____

Name of Patient (please print): _____

Patient's Date of Birth: _____

Additional Family Member Under 18: _____

Signature of Patient/Guardian (patient's 18 or older must sign their own release forms):

_____