MAUREEN R.
LIBBY
DMD
Prosthodontist & Oral Oncologist
Advanced Implant, Restorative & Cosmetic Dentistry
Dental Sleep Medicine

Record Release Form

I, _____ hereby authorize
(Patient's Printed Name)

_____
(Former Dentist's Name)

to provide_____

with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian, or POA of the patient, if the patient is unable to sign for themselves)

Address to where records should be sent:

_____

_____

_____

Date: _____

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