Medical Release Form

Patient Name:_____ **Date of Birth**: ____/____/____

I, _____, hereby authorize the doctor and staff of
Patient's Name (or Parent/Legal Guardian)

Eastland Family Dental to release records concerning my dental health. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records that pertain to my dental information.

Reason for Leaving Eastland Family Dental:_____

_____

Please select one:
_____ 1. Records given directly to me (or parent/guardian, if patient is minor)
_____ 2. Records to be sent to other dental office (complete below)

Name of Dental Practice/Dentist: _____

Address: _____

Telephone Number: _____

Email Address: _____

Effective Date of Authorization:
This authorization is effective through ___/___/___ until I cancel this consent. I understand that the I may revoke or terminate this authorization by submitting a request in writing to: Eastland Family Dental 19401 E. 40 Hwy., Ste. 180 Independence, MO 64055

PRINT Patient Name: _____
SIGN Patient Name: _____
(If child, signature of Parent or Legal Guardian) Date: ____/____/____

Signature of EFD Witness:_____
Date: ____/____/____