SUMMIT DENTAL GROUP

Zach Richardson, D.D.S.
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AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL RECORDS

Patient:_____

Birth Date:_____ Previous name (if any):_____

Present Address:_____

THIS WILL AUTHORIZE RELEASE OF DENTAL/MEDICAL RECORDS FROM:

Doctor:_____

Address:_____ City/St/Zip:_____

Phone:_____ Fax_____

SEND INFORMATION TO:

Name:_____

Address:_____ City/St/Zip:_____

Phone:_____ Fax_____

A photocopy of this authorization shall be considered as valid as the original.

_____ _____
Date Signature of Patient or Parent

_____ _____
Witness Relationship to Patient

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