FME FAMILY DENTAL

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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, _____, hereby authorize the release of my dental
(Name/ Date of Birth)
records from:

_____

(Dental office / Number / Email address)

to the Doctor's and staff at :

_____

(Dental office / Number/ Email address)

In addition, please forward dental records for the following dependents as well:

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Comments:

_____

Signed: _____ Date _____
(Patient, Parent, legal guardian)

CONFIDENTIALITY NOTICE: Health information is personal and sensitive information related to a person's health care. This message is being sent to you after appropriate authorization from the patient. You, the recipient, are required under state and federal law to keep this information safe, secure and confidential. Re-disclosure without proper consent could subject you to state and federal penalties, if you receive this fax/email in error, please advise immediately and destroy content of this message.