

**EMERALD WEST**  
Family Dentistry PLLC

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**AUTHORIZATION TO RELEASE  
CONFIDENTIAL DENTAL INFORMATION**

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
PHONE NUMBER

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE / ZIP

I HEREBY REQUEST THAT A COPY OR SUMMARY OF YOUR RECORDS, INCLUDING X-RAYS OR REPORTS THAT YOU HAVE WHICH CONTAIN INFORMATION RELEVANT TO MY PRESENT AND FUTURE TREATMENT BE RELEASED.

FROM: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AUTHORIZATION TO RECEIVE DENTAL CARE. HOWEVER, I DO HAVE TO SIGN AN AUTHORIZATION FORM TO GIVE MY PERMISSION FOR MY RECORDS TO BE RELEASED TO ANOTHER PARTY.

\_\_\_\_\_  
PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME IF SIGNED BY GUARDIAN

\_\_\_\_\_  
RELATIONSHIP