Emerald West DENTAL
CHAD D. HESS D.D.S. • RANDY MOSS D.D.S.

8850 W. Emerald St., Ste. 150 Boise, ID 83704
(208) 323-2294 Phone / (208) 323-2299 Fax
ewfd@emeraldwest.net to email records

AUTHORIZATION TO RELEASE CONFIDENTIAL DENTAL INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

I hereby request that you release a copy or summary of my dental records, including x-rays and reports that you have which may contain information relevant to my present and future dental treatment. Thank you.

Office authorized to release dental records:

Name of Office _____

Name of Dentist _____

Address _____

City,ST Zip _____

Phone _____ Fax _____

Email _____

Who they are authorized to release records to:

Emerald West Family Dentistry, PLLC
Name of Office

Chad D. Hess, D.D.S. / J. Randall Moss, D.D.S.
Name of Dentist

88500 W. Emerald St., Ste. 150
Address

Boise, ID 83704
City,ST Zip

(208) 323-2294 (208) 323-2299
Phone Fax

ewfd@emeraldwest.net
Email

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 _____

Office Use Only: Date: _____ Contact: _____ Date of X-rays: __/__/____ BW __/__/____ PANO
Notes: