



DENTAL RECORDS RELEASE FORM

Name: _____ Date of Birth: _____

AUTHORIZES: Elegant Implants

TO DISCLOSE TO: Self

INFORMATION TO BE DISCLOSED:

Specific records/information as follows:

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

EXPIRATION: This Authorization is good for one year unless dates filled in below:

From: _____ To _____

SIGNATURE OF PATIENT: _____ DATE: _____