Dental Images/Records Release Form

I, _____, authorize the release of all current dental records and dental images to Dental Associates.

Email images as Dexis files or JPEGS with the date taken to: dentalassociates@dasmile.com.

Records are being requested from:

DR._____

Address: _____

Fax #:_____

This will authorize the above name dental practice to release any and all dental/ medical information concerning my treatment, including copies of any medical/ dental reports, images, office records or opinions relating to my condition. The forgoing authority shall continue in force until revoked by me in writing.

Please honor a photocopy or fax of this authorization as fully as the original.

Patient, Parent or Guardian Signature: _____

Date: _____