PO Box 4935

Jackson, Wy 83001

teeth@lfdds.com

Release of Records

Patient Name _____ Date of Birth _____

Social Security Number _____- _____- _____

Day Time Phone (_____) _____- _____

Evening Phone (_____) _____- _____

Information to Be Released From:

Name of Dentist: _____

Dental Practice Name _____

Address:_____

Phone Number (_____) _____- _____

Fax Number (_____) _____- _____

Email Address:

I hereby authorize the release of the above information contained in my dental records which may contain personal and confidential information. I release you from any legal responsibility or liability that may result from this authorization.

Authorization is valid for 90 days and may be revoked in writing any time prior to 90 day by notifying the releasing party.

Patient Signature _____ **Date**_____

Relationship to Patient if a minor _____