CONSENT FOR RELEASE OF DENTAL RECORDS

I, ______________________________, do hereby consent to and

authorize ______________________________

to disclose to ______________________________

(address)______________________________

information in my dental records, including current and previous dental records from other practices and practioners, hospitals, and/or clinics which are part of my dental records.

My date of birth is ______________, and my Social Security number is

______________________. This information is strictly for purposes of

identification.

Patient______________________________

Date______________________________

If additional consent is necessary from a person authorized to give consent, other than the patient (such as parent, guardian, etc.,):

Patient______________________________

Relationship to the Patient______________________________