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_______________________________________