NORTH COAST
DENTAL GROUP

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

ADULT PATIENT RECORD RELEASE

I, (Print)_____, give permission to the North Coast Dental Group to release copies of my dental radiographs and/or clinical records.

SEND TO: _____
(Dr.'s Name)
_____
(address)
_____

Signed: _____Date:_____

CHILDREN'S RECORD RELEASE

I, (Print)_____, give permission to the North Coast Dental Group to release copies of the dental xrays/clinical records of my child(ren).

(child's name/DOB) _____

(child's name/DOB) _____

(child's name/DOB) _____

(child's name/DOB) _____

SEND TO: _____
(Dr.'s Name)
_____
(address)
_____

Signed: _____ Date:_____

Relationship to Patient_____

S Data Word7Doc SusanDoc 7/24/24