



AUTHORIZATION FOR RELEASE OF PATIENT RECORDS AND MATERIAL

Doctor's Name

Address

City State Zip

You are hereby authorized to utilize and/or release all or portions of my dental records or other materials as prepared by you in connection with clinical evaluation, treatment and care, without limitation, for the purpose of sharing the same with other dental practitioners for demonstration, training or other professional scientific purpose.

Witness

Patient Signature

Date

Patient Name

Address

City State Zip

Country

Return this form to the doctor named above.