RECORD RELEASE FORM

I, _____ hereby authorize
(Patient's name)

_____to forward my records to:

Stacey Dental S.C.
858 Jupiter Drive
Madison, WI 53718
608-222-7511/fax 608-222-9900
info@staceydental.com

My dental records may include:
report of examinations, findings, treatments, prognosis and copies of x-rays, which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed: _____
(Patient)

Signed: _____
(Parent, legal guardian, or custodian of the patient
If the patient is less than 18 years old)

Date: _____