RECORD RELEASE FORM

I, _____ hereby authorize
(Patient's name)

Stacey Dental S.C.
858 Jupiter Drive
Madison, WI 53718
(608) 222-7511
(608) 222-9900fax

To provide information to:
_____
_____
_____
_____

Please indicate information to be shared:

Yes/No Current x-rays
Yes/No Dentist/Hygienist notes
Yes/No Examination Notes

Purpose of information release:

_____

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: _____Date_____
(Patient)

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