Barrie Dental Specialists

# DENTAL RECORDS RELEASE FORM

**PATIENT INFORMATION:**

Name: _____ D.O.B.: _____

Authorizes: _____ on Date: _____

To Disclose to**:** ☐ Self ☐ Dentist ☐ Other _____

Delivery options: ☐ Email ☐ Fax ☐ Other: _____

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**Information to be Disclosed*:**

☐ Clinical Notes ☐ Radiology films/images ☐ Study Models

☐ Others

*Important: When transferring information to another dental office we only send written dental records, study models, and/or x-rays.

Send to: _____

Name of: **Dental Office/ Dentist / Myself/ Other**

Email Address: _____

Address: _____

Phone: _____ Fax: _____

**I release the above named from all medical/dental responsibility, liability or consequences that may arise from incomplete treatment following the release of my records.**

Signature of Patient/ Legal Guardian:

_____ Date: _____

*If signed by a person other than the patient, complete the following:* Individual is:

☐ parent/legal guardian ☐ Other (please state relationship): _____

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