CENTREVILLE FAMILY DENTISTRY

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ________________________________, hereby give my informed, voluntary
Name of Patient/Parent of patient

consent to release the following information concerning my/my child's dental records

to ____________________________________.
Name of organization or individual

This consent is effective for no longer than 3 months from the date of this release, or until

_____________________.
Date

The specific information to be released is: ________x-rays and/or dental records______________ .

The information can be transmitted: (please check)

- ❑ Over the phone
- ❑ Via fax or internet
- ❑ By mail

I understand that I can revoke this release at any time.

______________________________ ______________________________
Patient/Parent Signature Date

______________________________ ______________________________
Printed Patient/Parent Name Witness

____
If not patient, state relationship to patient

Name of Patient: ______________________________

Date of Birth: ______________________________