West Madison Dental
YOUR SMILE. OUR PASSION.

Records Release and Authorization

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I authorize, _____ ,
(previous dentist)

To disclose/release the following information:

- Radiograph records
- Periodontal treatment records
- Extraction dates of missing teeth
- Prior placement date of prosthetic/restorative treatment
- Prior referrals
- Other (models, etc.)

For the purpose(s) or need for which information is to be used:

_____ Transfer of records _____ Second Opinion

Other_____

Please release the records listed above to:

West Madison Dental
10871 County Line Rd. Suite A Madison, AL 35758
Phone: (256) 724-3530 Fax: (256) 325-0727
Email: info@westmaddental.com

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I hereby authorize the release of any information or records regarding my dental treatment to West Madison Dental. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

_____ _____
Patient Name (print) Person authorized to sign for patient

_____ _____
Patient Signature Date