Northern Colorado Family Dentistry
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Authorization to Release Dental Records

I authorize the release of dental information for myself and/or as guardian on my family's account for the individuals listed below.

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Please indicate the purpose(s) or need for transfer of dental information:

_____ Additional Professional Office
_____ Patient's Personal Records
_____ Second Opinion
_____ Other (indicate) _____

Please release requested transfer of dental information to the destination listed below:

Name: _____

Email: _____

Fax #: _____

I authorize this release, and certify that this request was made voluntarily. I understand that I may revoke this authorization, with written notification, for future execution.

Signature: _____ Date: _____