BRUMBACH
family dentistry

DENTAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my dental records, to the dentist/person/facility/entity listed below.

Patient Name ______________________________ Date of Birth ____________

Signature ______________________________ Date ____________

This information you may subject to this signed release form is as it follows:

Full Mouth X-rays ______________________________

Panorex ______________________________

Bitewing X-rays ______________________________

Treatment Plan ______________________________

PLEASE RELEASE MY DENTAL RECORDS TO THE FOLLOWING DENTIST:

BRUMBACH
family dentistry

609 Calgary Ct., Ste. 104,
Post Falls, ID 83854

208-777-1222 - **Fax** 208-777-4555

scheduling@brumbachdentistry.com