

**REQUEST FOR DENTAL RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_ authorize \_\_\_\_\_ to release copies of my  
(Patient/Legal Guardian Name) (Previous/Current Dental Office)  
\_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City, State, Zip Code)  
\_\_\_\_\_  
(Phone #) (Fax #)

dental records with respect to any dental care and treatment to:

Martin Family Dentistry, P.A.  
6130 Nieman Road  
Shawnee, KS 66203  
(913)631-4373  
Fax # (913)631-0882  
mfdpa@drmartindds.com

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and/or x-rays, which pertain to me.

I hereby release Martin Family Dentistry, P.A. from all legal responsibility or legal liability that may arise from the release of such information. I understand that I may revoke this consent at any time, except that the action has been taken in reliance upon it and that in any event this consent shall expire ninety (90) days after the date below.

A reproduced copy of this authorization shall be as valid as the original.

Patient Printed Name: \_\_\_\_\_ DOB \_\_\_\_\_

Patient Signature: \_\_\_\_\_  
(Patient/Legal Guardian)

Relationship to Patient: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Date: \_\_\_\_\_