AUTHORIZATION TO RELEASE DENTAL RECORDS

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

I, _____authorize Martin Family Dentistry, P.A. to release copies of my
(Patient/Legal Guardian Name)
dental records with respect to any dental care and treatment to:

_____

_____

_____
(Name and Address to whom the records will be sent)

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: _____