HIGH DESERT
DENTAL

# CONSENT TO RELEASE DENTAL RECORDS

Patient name and date of birth: (please print)

_____

Release records to:

_____
Name of dentist

_____
Mailing address

_____

_____
Email address

I hereby consent and authorize release of my dental records to the office named above:

_____
Signature and date
*If not patient, state relationship for authorization:_____

According to Colorado state law all dental records remain the exclusive property of the dental office of origin. With proper written authorization patients are allowed access and a copy of their dental records.

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