Authorization to Release Patient Records

I hereby authorize and request Dr. James Lichtsinn to release:

-Copies of the most recent dental x-rays.
-Summary of current dental findings.

Patient(s):____

Send to:____

____

Email:____

I understand that records may be sent electronically via email.

I hereby release Dr. James Lichtsinn from any liability related to disclosure of confidential or privileged information.

Please sign,____
(Patients over 18 must sign for themselves)

Date,______________________

and mail back to Dr. Lichtsinn's office.

Your address-if changed_______________________________

____

Southpointe Dental
3210 18th Street South, Suite A
Fargo, ND 58104
(701) 280-1941