Authorization to Release Patient Records

I hereby authorize and request Dr. _____ to release:

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

Patient(s):_____
_____

Send to:
info@southpointedental.com
or
Southpointe Dental
3210 18th Street South, Suite A
Fargo, ND 58104
(701) 280-1941

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

I understand that records may be sent electronically via email.

Please sign: _____
(Patients 18 and over must sign for themselves)

Address: _____
_____
_____

Date: _____