DENTAL RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Chart: _____

AUTHORIZES: **Emmet Dental PC**
89-02, 165 Street, MW29, Jamaica, NY, 11432

EXPIRATION: This Authorization is good for one year unless dates filled in below

From: _____ To: _____

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____

Delivery options:
☐ ***In Person***

☐ ***Email*** _____

☐ ***Fax*** _____

☐ ***Pick Up*** *(Please fill in below if other than patient, parent or legal guardian)*

To be picked up by, I hereby authorize _____ to pick up my records.
(Photo ID required.)

Send to: _____
Name of Person or Entity If Other Than Patient

_____
Address

(1) PHONE: _____ (2) PHONE: _____

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Emmet Dental PC

SIGNATURE OF PATIENT / LEGAL REP:

_____DATE: _____
If signed by a person other than the patient, complete the following:
Individual is: ☐ parent* legal guardian

Requested Information: (If applicable)

_____

_____