Authorization for Release of Records

To be completed by the patient or the patient's authorized representative:

Name of Patient *Phone*

Address *City* *State* *Zip*

I hereby authorize:

☐ Bluffs Dental

☐

Name of Provider *Phone*

Address *City* *State* *Zip*

to release my records to:

☐ Myself

☐ Bluffs Dental

☐

Name of Provider *Phone*

Address *City* *State* *Zip*

in the following manner:

☐ Copies to be Picked Up

☐ Copies to be Sent

Signature of Patient or Patient's Authorized Representative *Date*

Name of Patient's Authorized Representative (please print)

Description of Legal Authority to Act on Behalf of Patient

308-632-6331 **Fax 308-633-1362** **bluffsdental@bluffsdental.com**

{OFFICE USE ONLY}

☐ $0.00 Balance ☐ Appointments Cancelled ☐ Patient Inactivated ☐ Chart Archived