IMPERIAL FAMILY DENTAL CENTER

Authorization to Release Records

I give permission for the below-listed dental office:

Dental office name:_____ Provider name:_____

City, State, Zip code:_____

Office phone #_____ Office Fax #_____

To release the following:

Patient(s) name:_____

Patient(s) date of birth:_____

Records to be released:

__ Patient chart

__ Dental radiographs

__Periodontal charting

To:

Imperial Family Dental Center

510 W 12th street/PO Box 1408

Imperial, NE 69033

P: 308-882-5123 F: 308-882-5141

dentalteam@imperialfamilydentalcenter.com

Signature:_____**Date**:_____