Authorization to Release Dental Records

From:
Practice / Dentist Name _____

Phone Number _____

Email _____

Please release dental records, including current radiographs, periodontal charting, treatment history, and any other relevant information, to:

Brennan Dental
Jody L. Brennan, D.D.S.
Jennifer H. Ginn, D.D.S.
3107 W. McGraw St., Seattle, WA 98199
206.282.2416 (phone) ● 206.282.0825 (fax) ● dds@brennandental.com

Patient Name(s)	Patient Date(s) of Birth
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

Phone: _____

By signing below, I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that my dental records will be sent to the provider listed above by mail or electronically. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

_____ _____
Signature **Date**

_____ _____
Name of Authorized Representative (If Applicable) *Relationship to Patient*