CONSENT/AUTHORIZATION FORM

Date: ______________

____
Please **PRINT** name of Patient

____
Please **SIGN** name of Patient

____
Legal Representative/Guardian

____
Relationship of Legal Representative/Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparent, and any care takers who can have access to this patient's records):

Name: _____________________________________ Relationship: ________________

Name: _____________________________________ Relationship: ________________

Name: _____________________________________ Relationship: ________________

Witness: ____________________________________Date: __________________

Joe D. Arbutante D.D.S Family Dentistry

17357 Van Wagoner Rd., Suite 1
Spring Lake, MI 49456
PH (616) 842-0090
FAX (616)842-8970

REQUESTING RELEASE OF DENTAL RECORDS AND RADIOGRAPHS

DATE:
To/From Dr.____
Address: ____
____

Please Release My Dental Records and Radiographs to/from
Dr. Joe D. Arbutante D.D.S

Patients Name:____
Patients Phone:____

Signature:____

Please transfer any <u>Bitewing radiographs</u> within the last year and any <u>Full Mouth Series</u> within the last 5 years. Please also note any pending treatment the patient may have.

COMMENTS:
Please email to: arbutantedental@comcast.net