Grand Rapids Dentistry

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

Please release dental records and knowledge concerning dental health for the following:

Requesting Patient, Parent, Guardian or Authorized Representative of Patient:

_____ Birthdate: _____
(First and Last Name)

Additional Patient(s):

_____ Birthdate: _____Relation to Patient:_____
(First and Last Name)

_____ Birthdate: _____Relation to Patient:_____
(First and Last Name)

_____ Birthdate: _____Relation to Patient:_____
(First and Last Name)

_____ Birthdate: _____Relation to Patient:_____
(First and Last Name)

_____ Birthdate: _____Relation to Patient:_____
(First and Last Name)

_____ Birthdate: _____Relation to Patient:_____
(First and Last Name)

I hereby authorize the following dental office to release records or knowledge concerning my dental health or to Dr. Carol Baldwin and the staff of Grand Rapids Dentistry:

Dentist or Office Name: _____

Address:_____

Phone Number:_____

Email:_____

Signature: _____ Date: _____
(Signature of Patient, Parent or Legal Guardian or Authorized Representative)

Printed Name: _____

Please send the above listed records to:

Grand Rapids Dentistry
2100 Raybrook Street, Suite 107
Grand Rapids, MI 49546
Fax: (616) 243-7874
Email: office@dentistgr.com