PORTSCHY DENTAL PARTNERS OF MARIETTA

2483 POWDER SPRINGS ROAD SW, SUITE 100 • MARIETTA, GA 30064 • (770) 439-4141 • (770) 439-5326 FAX

IMPLANTS
COSMETIC DENTISTRY
CROWN & BRIDGE

MINOR ORTHODONTICS
DENTURES
FAMILY DENTISTRY

RECORD RELEASE FORM

I, ________________hereby authorize _____________to provide
(Patient or Guardian) (Dentist)

________________________________with copies of my dental records with
(Party to whom the records will be sent -- indicate address below)

respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including x-rays, which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed: ____ (Patient)

Signed: ____ Date: ________________
(Parent, legal guardian, or custodian of patient if the patient is less than 18 years old.)

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Address: ____

Date: __________________