TRUST CARE DENTAL
820 W Nolana Ave,
McAllen TX 78504, United
States
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contact@orderspanel.xyz

AUTHORIZATION TO RELEASE DENTAL RECORDS INFORMATION

I hereby release Dr.__________________and his/her employees from all provisions of the law prohibiting his/her dental office from disclosing any dental records, including x-ray files and reports of:

Pt's Name: DOB:

Name of dental office getting records from:
Phone # and Fax #:

I authorize release of my information to: TRUST CARE DENTAL

This release and authorization will expire without notice six months after the date listed below. You must be at least 18 yrs or older to request your records.

Name:(printed)______________________________

Signature:__________________________________

Witness:___________________________________

Date:______________________________________

"This release is for a patient coming into our office"