Snowy River Dental
FAMILY & COSMETIC DENTISTRY

Record Release Form

Patient:

_____ _____ _____
Last Name First Name MI

_____
Date of Birth

I hereby request and authorize: _____
(Previous Dentist's Name)

To release a copy of the following patient records:

□ X-rays □ Periodontal Chart(s) □ Photographs □ Full Dental Records

To: Dr. Danton Bradshaw DDS
Snowy River Dental
304 S Main St
Bellevue, ID 83313
P-(208) 788-2006
F-(208) 928-7894
Email-*snowyriverdental@gmail.com*

I acknowledge that data to be released MAY INCLUDE material that is protected by federal laws and that is applicable to ANY and ALL of the above.

My signature below authorizes release of all such information.

_____
Signature of Patient/Responsible Party Date

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed, unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you from the records, whose confidentiality is protected by Federal and/or State regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.