CONSENT TO RELEASE / REQUEST DENTAL RECORDS

I _____ do hereby consent and authorize
Patient Name

_____ to disclose to Dr. Roy Daniels, DDS,PLC
Previous Dentist Name/Office

Information in my record, including current and previous dental records from other practitioners, hospitals and/ or clinics which are part of my record.

Copies of the following records are specifically requested:

- □Progress notes
- □Letters/Reports to/from Specialist
- □Periodontal Charting
- □Radiographs
- □Medical History Forms

I also consent to the release of dental records by Roy Daniels, DDS, PLC in the event any additional information is needed by my insurance company or other providers.

Patient or guardian signature: _____
Print: _____
Relationship to patient: _____
Date: _____

Please send this to:

Roy Daniels, DDS, PLC
130 Navajo Drive
Sedona, AZ 86336-3718
Phone: 928-282-3246
FAX: 928-282-5846
Email: dentistsedona@gmail.com

If you have any questions, please call our office: 928-282-3246. We prefer that digital xrays are sent in a digital format via e-mail or disk. We have the ability to use Kodak PracticeWorks digital image formats.