Authorization for Release

To: _____
Previous Dentist or Practice Name

Location: _____
Address

I request and authorize for my dental images and records (such as progress notes, periodontal charting, etc.) to be released from the office as listed above to Clearwater Dental. I understand this authorization includes all records necessary to support my dental care.

Patient: _____
First name Last name

Date of birth: _____

Please release records to ***frontdesk@clearwaterdentalec.com***

Patient Signature (parent/guardian if minor): _____

Date: _____

Clearwater Dental
4237 Southtowne Drive
Eau Claire, WI 54701
Phone: (715) 514 - 5300
Fax: (715) 514 - 4115
frontdesk@clearwaterdentalec.com

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