RECORDS RELEASE REQUEST FOR TREATMENT PURPOSES

Date _____

Patient's Name (please print clearly) _____

I hereby authorize _____
(name of dentist, physician or clinic)
to release dental records and medical records relevant to dental treatment, or copies of such for the aforementioned patient to the following office:

Dan Copp, D.D.S., Inc.
Tel: 805.544.8805
Ron Barbieri, D.D.S., Inc.
Tel: 805.543.5321
Fax: 805.543.0753
1131 Pacific Street
San Luis Obispo, CA 93401
barbiericoppdds@gmail.com

_____ Date _____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please *print* name of Patient, Parent, Guardian or Personal Representative

If not signed by the patient please indicate relationship:
- □ parent or guardian of minor patient
- □ guardian or conservator of an incompetent patient
- □ beneficiary or personal representative of deceased patient