DAN COPP DDS • MIKE ROBERTS DDS • ALINA BORCHARDT DDS

COPP DENTAL GROUP

GENERAL AND COSMETIC DENTISTRY

Authorization to Release Dental Records for Treatment Purposes

I, (print patient or guardian name)_____hereby authorize the release of dental records and medical records relevant to dental treatment, or copies of such to the following office:

Full Dr.Name_____

Street Address_____

City _____ State _____ Zip Code_____

Practice Phone Number: _____

Practice Email Address: _____

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

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

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