AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION

STORYBOOK DENTAL

NAME OF PATIENT:_____

DATE OF BIRTH:_____

STORYBOOK DENTAL REQUESTS THE FOLLOWING INFORMATION:_____

_____

_____

_____

NAME OF OFFICE REQUESTING RECORDS FROM/ OR SENDING RECORDS TO:_____

_____

_____

_____

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below. Storybook Dental, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

PARENT OR LEGAL GUARDIAN SIGNATURE_____

DATE _____

2115 SE 192nd Ave Suite 106

Camas, WA 98607

Phone: 360-216-1130 Fax: 360-216-1125

Email records to: Contact@storybookdental.com

5-26-21