Release of Dental Records

I, _____, hereby authorize
(Patient's Name)

_____ to provide
(Former Dentist's Name)

Brockman Family Dentistry with copies of my dental records with respect to any dental care and treatment that I have received. I understand that this consent is voluntary and the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and any other records that pertain to me.

Previous Dentist's Information

Dentist/Specialist:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Patient's Information

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Patient/Legal Guardian_____
(Signature)

Release to:

Brockman Family Dentistry, INC. Phone: 303-799-4333
John R. Brockman, DDS
11949 Lioness Way, Suite 200
Parker, CO 80134
Email: brockmanfamilydentistry@gmail.com