PREMIERE DENTISTRY OF TAHLEQUAH
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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name _____ Date of Birth _____

I request and authorize Premiere Dentistry to release the health care information of the patient named to:

_____
_____
_____
_____
_____

This request and authorization applies to:

- ☐ Treatment Records and Current X-Rays
- ☐ Other: _____

I authorize the release of all records regarding dental treatment to the person(s) and/or dental office(s) above.

Patient or Parent/Guardian Signature _____

Date _____

This authorization expires one year from date of signature.