

RECORDS RELEASE FORM

I, give permission	on for
(name of patient or legal guardian)	(name of releasing doctor)
Phone number	
(phone number of re	eleasing doctor)
to release medical information (Diagnosis Codes, X-rays, Clinical N patient	lotes and Operatory Notes) on the following to the dentist listed below.
(name of patient)	
Patient's Date of Birth/	
Signature of patient or legal guardian:	
Date:/	
Email to: frontdesk@tennesseedentalcare.com	