ROCKY POINT
FAMILY DENTISTRY

Authorization for Release of Information

Today's Date: _____

Patient name: _____

Date of birth: _____

What to release (please circle): Radiographs - Records

If receiving records from another office:

- I hereby authorize Rocky Point Family Dentistry to receive information or records regarding my dental treatment. Please send any current radiographs or any records that would be helpful in my dental treatment to Rocky Point Family Dentistry at records@rockypointsmiles.com

If requesting to send records to another office:

- I hereby authorize Rocky Point Family Dentistry to release my information or records regarding my dental treatment to the following recipient:

- Name: _____

- Email: _____

- Phone number: _____

Patient/Parent/Guardian Signature: _____ Date: _____