Records Release Form

I, ____, hereby authorize
(Patient's name)

____
(Former dentist's name)

to provide **Flint Hills Dental PA** with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed: ____
(Patient)

Signed: ____
(Parent, legal guardian, or POA of patient, if patient is unable to sign for themselves)

Records should be sent by email or FAX to:

admin@flinthillsdentalpa.us
(785) 321-3466

Date: ____________________________________