DIRIGO DENTISTRY

DENTAL RECORDS RELEASE FORM – TO DIRIGO DENTISTRY

Patient Name: _____ Patient Date of Birth: _____

By signing this for, I authorize the following:

The information is to be **disclosed by:**		And **provided to:**	
Provider:		Provider:	**Dirigo Dentistry**
Address:		Address:	**Mt Hope Ave Ste 2**
City, State:		City, State:	**Bangor, Maine**
Zip Code:		Zip Code:	**04401**
Phone:		Phone:	**207-942-2511**
Fax:		Fax:	**207-907-4525**
Email:		Email:	**appointments@dirigodentistry.com**

I understand that the specific type of information to be disclosed include a detailed report of examinations, finding, treatments, prognosis, and copies of any and all records, including x-rays, which pertain to me.

_____

(Please Print Name of Patient, Parent, or Guardian)

_____

(Signature of Patient, Parent, or Guardian)

_____

(Date)

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