Sam Kretzschmar, D.D.S.
General & Cosmetic Dentistry

AUTHORITY TO RELEASE DENTAL RECORDS AND INFORMATION

Doctor's Name: _____

Address: _____

_____

You are hereby authorized to furnish and release to Dr. Sam Kretzschmar, copies of the following information concerning my dental care.

( ) Health History
( ) Diagnostic Casts
( ) Dental Health Status
( ) Prescription Records
( ) Treatment Records
( ) Other _____

( ) Radiographs (FMX <5yrs, BWX <1yr, PANO <5yrs)
( ) Reports
( ) Charts
( ) Insurance Reports
( ) Photos

The foregoing authority shall continue in force until revoked by me in writing. All prior authorizations, if any, are hereby canceled.

Print Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Signature: _____ Date: _____
*If a minor, parent or guardian must sign.

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