



P R E M I E R E
D E N T A L

AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS

I, _____ hereby authorize Premiere Dental, to send/receive all dental records, including x-rays, charting, and photographs from the dental provider/entity listed below:

Practice Name: _____ Address: _____

Phone: _____ E-mail: _____

Reason for request: _____

Patient/Guardian Signature: _____ Date: _____