Record Release Form

I,_____ hereby authorize
(patient's printed name)

_____
(former dentist's name)

To provide Biddeford Saco Dental Associates 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.

As applicable, please send all records for the following persons for whom I am either the parent, guardian or POA.

Child Name:_____ Date of Birth: _____
Child Name:_____ Date of Birth: _____
Child Name:_____ Date of Birth: _____
Child Name:_____ Date of Birth: _____
Child Name:_____ Date of Birth: _____

Signed,_____
(patient)

Signed,_____
(*patient, parent, legal guardian, or POA if patient is unable to sign for themselves)*

Printed name_____
(patient, parent, legal guardian, or POA)

Date_____

Please mail or fax all records to:
Biddeford Saco Dental Associates
323 Main Street, Saco ME 04072
Tel. : (207)-282-9962
Fax : (207)-283-4299
Email : contact@bsda.com