



# 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](mailto:contact@bsda.com)

