BRUMBACH
family dentistry

DENTAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my dental records, to the dentist/person/facility/entity listed below.

Patient Name: _____ **Date of Birth:** _____

Signature: _____**Date:** _____

_____Full Mouth X-rays

_____Panorex

_____Bitewing X-rays

_____Treatment Plan

Name of previous dental office: _____

Please release my dental records to the following dentist: _____

609 North Calgary Court, Suite 104, Post Falls, ID 83854 | (208) 777-1222
scheduling@brumbachdentistry.com | www.brumbachdentistry.com