Authorization to Release Dental Records

Hudson Valley Dentistry
Gen Ohkawa, DDS
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Saugerties, NY 12477
(518) 678-3111
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Date_____

Dear Dr. Ohkawa:

I authorize the **release of dental and medical records** for the following patient(s)

patient name(s):_____

_____

to be **released to**:

Name: _____

Address: _____

_____

Tel: _____

Fax: _____

Email: _____

*Please sign consent to email form if you would like your records to be emailed.

_____ _____

Signature (patient, parent, or guardian) Name of signee