Kindred Oaks
DENTISTRY
Brandy R. Buckner, DDS

Authorization for Release of Dental/Medical Records

Patient Name: _____ Date of Birth: _____

Present Address: _____

Phone Number: _____

This will authorize the release of dental/medical records from:

Doctor/Office: _____

Address: _____

Phone Number: _____ Fax Number: _____

Send information to:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Patient/Guardian Signature: _____

Patient/Guardian (Print): _____

Relationship to Patient: _____

Date: _____