JP Dental and Implant Center
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By signing this form, I authorize JP Dental to release confidential health information about me, by releasing a copy of my dental records.

Print Name of Patient:_____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

❑ Patient notes
❑ X rays
❑ Patient chart
❑ Other (please specify) _____

To: _____
(DOCTOR/HOSPITAL)

Address:_____

City: _____ State:_____ Zip Code: _____

Patient Signature: _____ Date: _____