MEDICAL/ DENTAL RECORDS RELEASE

I, ______________________________________ (DOB)________________, hereby authorize,

______________________________(*former dental practice*), to release all dental records for

- **Myself**,
- and:

____(name) _________________(DOB)

____(name) _________________(DOB)

____(name) _________________(DOB)

____(name) _________________(DOB)

To Storyville Family Dentistry,

815 N Causeway Blvd., Metairie, LA 70001

Email: storyvilledentistry@gmail.com

These records include all, but not limited to:

Radiographs / Photos

Health History

Dental Health Status

Treatment Records

Prescription Records

Reports

Charting

Referral documents

Specialist Correspondence

Clinical Notes/Ledger Notes

This consent is effective until I provide written authorization to cancel this consent.

____ ________________________

Signature Phone Number Date Requested