Stephanie M. Busch-Abbate, D.D.S., PLC
3048 W. Main Street
Kalamazoo, MI 49006
Phone: (269) 381-3890 Fax: (269) 381-9743
office@gentledentistrykzoo.com

Authorization for Release of Records

Date:_____

Patient Name(s): _____ DOB: _____

I,_____ ___, authorize the release of all dental records for the above named patient(s)

☐ To Gentle Dentistry – Please forward to the address above.

☐ From Gentle Dentistry—please forward to the following:

Name/Phone number : _____

Email Address: _____

This authorization shall be effective following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the above-named dentist. A photocopy of this authorization shall constitute a valid authorization. The dentist and his/her employees are released from legal responsibility or liability for the release of the above information to the extent and authorized herein.

Print Name:_____ Signature:_____

Relationship to Patient(s):_____

Reason for Transfer:

_____

_____

The recipient of the enclosed information is not authorized to use this patient's dental/health care records for any purpose other than for that stated above or to disclose any information from the record to any other person or facility without specific written authorization from the patient to do so.