AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Previous Name (if applicable): _____

I AUTHORIZE THE RELEASE OF MEDICAL/DENTAL RECORDS FROM:

Doctor Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

PLEASE SEND RECORDS TO:

Boise Integrative Dentistry

398 S. 9th Street, Suite 230

Boise, ID 83702

Phone: 208.336.0003 Fax: 208.336.1092 Email: jjuhnke@boise-dentist.com

_____ _____

Patient or Legal Guardian Signature **Date**