## 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

7878 Ustick Road, Suite 101

Boise, ID 83704

Phone: 208.376.2920 Fax: 208.376.8509 Email: morozco@boise-dentist.com

____________________________________________ ____________________________

**Patient or Legal Guardian Signature** **Date**