EASTMAN CRAIGHEAD

PERIODONTICS + IMPLANTS + LASER SURGERY

AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: _____ Date of Birth: _____

This letter will authorize Eastman Craighead Periodontics to provide a copy, summary, or narrative of my dental records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

☐ Radiographs/CBCT Scans
☐ Clinical Pictures
☐ Confer verbally and/or electronically with other person/office about information in my records
☐ Other:_____
_____

to the following person/office:

Name / Office: _____

Address: _____

State: _____ Zip: _____

Phone: _____ Fax:_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Title (e.g., Guardian, Executor, etc)

LAKEWOOD RANCH | 6310 Health Park Way, #240 Bradenton, FL 34202 | 941.351.3000 | Fax: 941.351.2767
WEST BRADENTON | 1906-G 59th St W. Bradenton, FL 34209 | 941.792.3899 | Fax: 941.351.2767
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