Authorization for the Release of Dental Records

I hereby authorize the office of:____

Phone Number:____________________Fax Number:____________________

to release the information in the dental record of:____________________________

Please send to:	Dr. Nathan M. Tanner, DMD, LLC	Phone: (541) 955-4519
	1840 East Barnett Road, Suite B	Fax: (541) 500-0010
	Medford, Oregon 97504	Email: smile@drtanner.com

I understand that I may receive a copy of this authorization.

____ ____________________
Signature *Date Signed*

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Please place a copy in the patient's chart.