5125 Roe Blvd, #100, Roeland Park, KS, 66205
913-831-4300
Email: smile@completecarekc.com

Request for Release of Information

I, ____________________________________ , ________________hereby authorize
(Patient Name) (Patient date of Birth)

____
Dental Office

____
Address

____
City, State, and Zip Code

to release my dental records, including X-Rays, to Complete Care Dental. I hereby release the above listed Dental Office from liability in this disclosure of such information.

____

Patient's (or Legal Guardian's) Signature Date