Julie A. Fattore, DDS
A Partner in Your Dental Wellness

RECORD RELEASE FORM

I, _____ hereby authorize _____ to provide
(Patient Name) (Dental Office)

Dr. Julie Fattore
39520 Woodward Ave, Ste. 105
Bloomfield Hills, MI 48304
(248) 430-6331
(248) 556-2103 FAX
melissad@yourdentalwellness.com

with copies of my dental records with respect to any dental care and treatment

Please mail my records _____
Pease email my records _____
I will arrange to pick-up my records _____

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis, and copies of any and all records, including x-rays, which pertain to me. I would like the following records to be duplicated.

_____ Radiographs
_____ Report of treatment and examination
_____ Complete dental record

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed: _____ _____
Patient or Guardian Signature Date

Patient Address: _____
Street

_____
City State Zip

_____ _____
Area Code/Phone (best)