PINE RIDGE DENTAL
5140 South 56th Street
8545 Executive Woods Drive
(402) 423-1100
Email: ew@pineridgedental.com
Fax (402) 423-1368

Authorization for Release of Dental Records

Patient's Name _____ Date of Birth _____

Dependents you're requesting records for:

Name_____ Date of Birth _____
Name_____ Date of Birth_____
Name_____ Date of Birth_____

I authorize Pine Ridge Dental to release copies of my dental records and medical records relevant to dental treatment. I request my records be transferred to:

Reason for Release: _____

_____

Please allow up to two weeks for records processing and delivery

_____ _____
Signature/Parent/Guardian Date

Name of Office: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax Number: _____

Email: _____