## RECORDS RELEASE AUTHORITY

TO:_____ I,_____
Patient's Name

hereby request that you release the following records and data pertinent to your treatment of me:

from_____to_____

on to:

**MILLHOPPER FAMILY DENTISTRY**

www.millhopperfamilydentistry.com
please email xrays to: info@millhopperfamilydentistry.com
3510 NW 43rd Street
Gainesville, FL 32606
Tel: (352) 377-1705 Fax: (352) 377-1093

Types of records requested (e.g. lab tests, specific records, summary of records etc.)_____

_____

Pick one: ☐ Fax ☐ Paper Copy ☐ USPS ☐ Via encrypted email

☐ Via regular (unencrypted) email- I understand that there are possible risks due to the insecure nature of unencrypted email.

_____ _____
Patient's Date of Birth Signature of Patient, Parent, Guardian, or Personal Representative

_____ _____
Witness Please print name signed above

_____ _____
Date Relationship to Patient