



609 W. South St. / Mason MI 48854

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Please include all records and radiographs for the below mentioned patient & their spouse/family members if indicated. Thank you!

Patient Name: _____ Patient Date of Birth: _____

Please apply this release to the above patient's: ☐ Spouse ☐ Children

The above listed patient has authorized the release of dental records and radiographs to:

Dr. Corey Cook, DDS

609 W South St

Mason, MI

Ph: 517-676-9566

Fax: 517-676-0318

frontdesk@ccookdds.com

AUTHORIZATION & RELEASE

I authorize the release of my personal and confidential information as described above. I understand that this is voluntary and that the information is protected by law. I understand it is within my rights to withdraw consent in writing at any given time. This is in accordance with the Health Information Portability and Accountability Act (HIPAA).

Signature

Date

Parent/Guardian Signature
(if under the age of 18)

Date