COOPER DENTAL GROUP
ORMOND BEACH

Records Release Request to Individual

I hereby authorize Cooper Dental Group to release information related to my benefits, lab cases, appointments, financials, and treatment plans to the individual listed below. This authorization is granted for the purpose of allowing disclosure of my dental information to those individuals who I feel should have access to it.

Name:_____ **Relationship:** _____

Phone: _____

Records Release Request from Organization

To (Doctor/Physician):_____

Address: _____

City:_____ **State:**_____ **Zip:**_____

Phone: _____ **Fax:** _____

I authorize the release of dental records and x-rays relevant to dental treatment, or copies of such, and request that they be transferred to:

Cooper Dental Group
1275 West Granada Blvd Suite 1
Ormond Beach, Fl 32174
386-672-0955

_____ _____

Print name of patient **Date of Birth**

_____ _____

Signature (patient parent, guardian) **Date**

COOPER DENTAL GROUP
ORMOND BEACH

1275 W. Granada Blvd.
Suite 1
Ormond Beach, FL 32174

PHONE (386) 672-0955
FAX (386) 672-5177
E-MAIL Cooperdentalgroup@yahoo.com