FAMILY FRIENDLY PRACTICE

Dr. Bart A. Samuelson, P.C.

Dr. Jeri L. Scranton, P.C.

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient:_____

Birth Date:_____**Previous name (if any):**_____

Present Address:_____

THIS WILL AUTHORIZE RELEASE OF DENTAL RECORDS FROM:

Doctor:_____

Address:_____**City/St/Zip:**_____

SEND INFORMATION TO:

Name:__**Black Hills Area Dental**

Address:200 Federal Avenue

City/St/Zip: Rapid City, SD 57702

PLEASE FORWARD Digital X-Rays to:

info@blackhillsareadental.com

Phone: 605-348-4657 FAX: 605-348-4382

A photocopy of this authorization shall be considered as valid as the original.

_____ _____

Date **Signature of Patient or Parent**

_____

Relationship to patient if signed by parent