10233 W. Overland Road
Boise, Idaho 83709
(208) 323-4700
Fax: (208) 323-9409
frontoffice@allseasonsdentalboise.com

Patient Authorization Release of Dental Records

I, the undersigned, ____________________________________________ (print name)
consent to the release of my dental records and/or radiographs including related clinical notes and treatment plans (if applicable) from:

Name and Address of Dental Office:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Signature ________________________________________________ Date ______________

Patient(s) name(s) and date(s) of birth: ________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________