RECORDS RELEASE AUTHORITY

DATE: _____

I hereby authorize the release of dental records and copies of insurance information for the individual listed below:

Name	Date of Birth

Please include history of periodontal treatments and crown/bridge seat dates.

These records are to be transferred to:

CENTRAL PARK DENTISTRY
23 N FEDERAL AVE
MASON CITY, IA 50401
CPD@CENTRALPARKDENTISTRY.COM
Fax: 641-423-1697

_____ _____

Name Date