RECORD RELEASE FORM

I, _____ hereby authorize

(Patient's name)

_____ to forward my records to:

Stacey Dental S.C.

858 Jupiter Drive

Madison WI 53718

608-222-7511/fax: 608-222-9900

frontoffice@staceydental.com

My dental records may include:

report of examinations, findings, treatments, prognosis, and copies of x-rays, which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed: _____

(Patient)

Signed: _____

(Parents, legal guardian, or custodian of the patient if the patient is less than 18 years old)

Date: _____