Elevated Dental
2109 N Frontage Road, West
Suite B
Vail, CO 81657
Phone: (970)476-3991
Fax: (970)476-1625
Email: info@elevateddentalvail.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION

PATIENT NAME: **DOB**:

RELEASE TO:

RECIPIENT EMAIL ADDRESS OR PHONE:

REASON FOR YOUR TRANSFER:

I REQUEST THE FOLLOWING INFORMATION (indicate below)

___COPY OF CURRENT DENTAL X-RAYS

____COPY OF COMPLETE DENTAL CHART

AUTHORIZATION

PATIENT NAME: (PRINT) _____

PATIENT SIGNATURE: _____ DATE: _____

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If necessary, person authorized to sign for patient:

SIGNATURE: _____ DATE: _____

STATE HOW YOU ARE AUTHORIZED: _____