ALASKA PREMIER DENTAL GROUP LLC

Authorization for Release of Dental Records

Today's Date: _____ **Drivers License Number:** _____
Patient **Current Address:** _____
Phone: _____
Patient(s) Name and Date of birth: _____
_____
Requesting: Records and x-rays _____ Pano only _____ x-rays only _____
Records to be: Mailed _____ **or** Picked Up in Ofice _____ on _____

I authorize Alaska Premier Dental Group LLC to release my records to:

Dr.'s Name: _____ Phone: _____
Address: _____ Fax: _____
_____

Please request my records from:

Dr.'s Name: _____ Phone: _____
Address: _____ Fax: _____
_____

Reason for request:

Referred out: ____ Moving: ____ Other: ____ (Explain) _____
_____
_____

Signature of Patient or Guardian: _____

Staff initials: _____ Date Records mailed or picked up: _____

Administrative Use Only:
Account Balance: _____ Approval for release: _____

6611 DeBarr Road, Suite 200, Anchorage, Alaska 99504 • Tel 907.337.0404 • Fax 907.337.6086
6611 DeBarr Road, Suite 100, Anchorage, Alaska 99504 • Tel 907.337.1322 • Fax 907.929.2178
935 Westpoint Drive, Suite 202, Wasilla, Alaska 99654 • Tel 907.373.5930 • Fax 907.373.7702
www.smilealaska.com