HUCKABEE & HUCKABEE
FAMILY AND COSMETIC DENTISTRY

Huckabeefamilydentistry.com

Date_____

Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby authorize the doctors and staff of Huckabee & Huckabee D.D.S. P.C. to release records or knowledge concerning dental health for (patient) _____ to:

Full Dr. Name _____

Street Address _____

City, Zip Code _____

Practice telephone number: _____

I specifically request that you release copies of:

□Most recent radiographs □ Treatment notes
□My records regarding a specific condition or period of time
_____

Please state why you are submitting this request

□Second Opinion
□Receiving Dental Care Elsewhere
□Providing a Specialist with Records
□Moving
□Change of Insurance
□Other _____

Please bring this completed form to the office or fax it to (816) 350-1975. In accordance to Missouri law, patients are entitled to access to copies of all records; however, original records must remain at the property of Huckabee & Huckabee D.D.S. P.C.

Printed name (patient or guardian name)_____

Signed (patient or guardian name) _____