Dental Designs by Holst & Associates
401 East Robinson
Knoxville, IA 50138
(641) 828-8778

RECORD RELEASE FORM

I, ____ hereby authorize
(PATIENT'S FULL NAME)

Dentist's Name ____

Dentist's Address ____

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to provide the office of Dental Designs with copies of my dental records with respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examination, findings, treatments, prognosis and copies of any and all other records including x-rays, which pertain to me.

Patient or Guardian Signature____ Date ___________________________