Carano Dental Group

RELEASE OF RECORDS AUTHORIZATION

I ___________________________________, DOB________________ request and authorize

Office name: ____

Office Address: ____

Office Phone: ____________________ Office Fax: ________________________

to release any and all parts of my dental patient information in the form of, but not limited to, copies of x-rays, medical health information, copies of correspondence and narrative summaries to:

Carano Dental Group: 1670 Lincoln Hwy East, Lancaster, PA 17602
Office 717-394-1067
Fax: 717-394-5441
Please contact us with questions or concerns.

▪Our office has digital x-rays. Please send the x-rays to caranodentalgroup@comcast.net

***Record transfer of additional family members**:
____
____
____

Patient Signature: _________________________________ **Date**: __________________
I understand that by making this request I am waiving any Physician (Dentist) Patient confidentiality privilege that I or members of my family may have to this information.

Patient Record Information

Patient Name: ________________________________

Last Exam: ________________________________

Last Prophy: ________________________________

FMX/Pan: ________________________________

Bitewings: ________________________________