HERSHEY DENTAL ASSOCIATES, L.L.C.

Authorization to Release Records and X-rays

To be completed by each patient individually.

Patient Information:

Name: _____

Address: _____

Date of Birth _____

I, the above named patient, authorize the release of my records and x-rays from:

Doctor/office name: _____

Address: _____

Phone: _____

Send To:
Hershey Dental Associates, LLC
253 Hershey Road
Hummelstown, PA 17036
info@hersheydental.com

If the request is by a patient:
Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:
Print the Name of the Personal Representative: _____
Relationship to the Patient: _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.
Signature of Personal Representative: _____ Date: _____

Employee Responsible (initials):_____