AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name:_____**Date of Birth:**_____

Social Security Number:_____

Address:_____

City:_____**State:**_____**ZIP Code:**_____

Phone:_____

RELEASE MY MEDICAL/DENTAL RECORDS FROM:

Name:_____

Phone:_____

Fax:_____

TO:

Angela R. Klingensmith, DDS
3360 Tremont Rd.
Suite 150
Columbus, OH 43221
614-451-5161
klingensmithdds@rrohio.com

Please release a copy of all my medical/dental records, including but not limited to, progress notes, operative notes, laboratory results, diagnostic tests, and original x-rays submitted to your office by Dr. Angela Klingensmith.

By My Signature, I Authorize Release of Medical/Dental Records

Patient:_____**Date:**_____