AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION TO PATIENT AND / OR NEW DENTAL OFFICE

Stephen D. Burch, D.D.S.

Diplomate, I.C.O.I.
Diplomate, A.S.O.
Fellow A.G.D

Sedation Dentistry

General Dentistry

Reconstructive Dentistry

Neuromuscular Dentistry

Periodontal Therapy

Treatments for TMJ,

Head, Neck & Face Pain

Smile Rejuvenation

Comprehensive Dental

Implant Service

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Name of Patient ____

Address of Patient: ______________________________________
Number & Street

____
City State Zip

Social Security #__________________ Date of Birth:_________

I hearby authorize the release of my pre-operative medical pre-operative tests to Stephen E. Burch, DDS.

Please include most current H&P, EKG and blood work.

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety days from the date below.

Dr. Stephen E. Burch and the corporation for 3D Dental Solutions are hereby relieved all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

______________________________ __________________
Signature of Patient or Legal Guardian Date