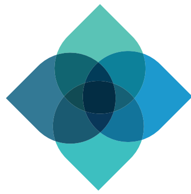

IntegrativeDental OF DENVER

James Bieneman, DDS
Nathan Wecker, DDS

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Release of Records

Patient Information and Consent Form

I, ______________________________ hereby authorize Integrative Dental of Denver to provide ______________________________ with copies of my dental records with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me. This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Patient Information:

Full Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ______________________________

Phone: ______________________________

Send Records To:

Dentist Name: ______________________________

Street Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

Email: ______________________________

____
Patient Name

____
Signature of Patient/Guardian

____
Signature of Doctor

____
Date