

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Huy Do, MS, DDS
1301 Sunnyvale-Saratoga Road, Suite 2
Sunnyvale, California 94087
(408) 732-2112

I hereby authorize:

Doctor:

Address:

Phone:

to furnish radiographs and record of treatment regarding _____
to Dr. Do who will as of this date provide necessary dental care. Thank you in advance for your
prompt attention.

Signed: _____

Date: _____

Relationship to patient (please circle one): self parent guardian

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PLEASE COMPLETE

Date of last visit: _____ Date of last x-rays: _____
Date of last prophylaxis: _____ Date of complete series: _____
Date of last fluoride: _____ Date of last bite wings: _____

Comments:

Please keep a completed copy for your records and return the original. Thank you!

HIPAA NOTE:

This information is extremely private. If you receive this fax in error, you are to immediately call
our office and then destroy the fax.