# RECORDS RELEASE

TO: REUBEN A JAMHARIAN DMD, LLC DATE:

PATIENT:

DOB:

I authorize the dental office of Reuben A. Jamharian DMD, LLC or any member or employee of your office or association who has examined or treated me, to release complete and legible copies of any and all radiographs, records, concerning my physical condition, care and treatments to:

Dr._____

Address_____

_____

Phone_____

EMAIL _____

This authorization includes, but is not limited to medical reports, clinical notes, patient x-rays and other diagnostic and pathologic tests (including a copy of the report), a diagnosis and prognosis.

I hereby expressly waive any laws, regulation, and rules of ethics which might prevent any person or entity that has examined me in a professional capacity, or otherwise, from releasing the information and records requested.

A photocopy of this Authorization, which contains my signature shall be considered as effective and valid as the original and shall be honored by those to whom it is sent or provided.

Name: _____

patient, parent or guardian

Signature: _____

Date: _____