ROCKY MOUTAIN SMILES
PAUL R. BIGUS, D.D.S.
3214 W EISENHOWER BLVD, STE B
LOVELAND, CO 80537
PH: 970-667-1293 FAX: 970-663-6568

AUTHORIZATION TO RELEASE DENTAL INFORMATION

TO: _____

PHONE # _____ FAX # _____

PATIENT: _____

DOB: _____

I authorize the above named doctor/dentist to release the information specified below:

___ Copy of complete dental chart

___ Copy of current dental X-rays

___ Other (e.g. models described below

___ All treatment rendered in this office

___ Limited to treatments dates and/or condition described below

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PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED

___ Transfer of Records ___ Second Opinion ___ Other (indicated)

Please email requested information to the name and email below:

Rocky Mountain Smiles drbigus@drbigus.com

I certify that this request has been made voluntarily and the information given above is the accurate to the best of my knowledge. I understand that I may revoke this authorization at any time.

Signature _____ Date _____