



1553 N Canal BLVD, STE A
Redmond, OR 97756
541.923.2880 ph
541.923.2881 fax

AUTHORIZATION TO RELEASE RECORDS

Patient: _____ Date of Birth: _____

Authorization, for the patient listed above, has been given to release: Medical/Dental Records:
Financial Records:

Records are to be released:

From: _____

To: Aesthetic General Dentistry, Brook Derenzy, DDS
1553 N Canal BLVD, STE A Redmond, OR 97756
541.923.2880 ph 541.923.2881 fax
info@derenzydental.com

Use of this information shall be limited to the following purposes:

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until: _____

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

Signature _____ Date _____

If authorization is being given on behalf of the patient, complete the section below.

Name: _____

Source of Authority: _____
(i.e. Parent or Power of Attorney)