



Phone: (907) 562-6648  
Fax: (907) 561-8385  
Email: [alaskadentalgroup@alaska.net](mailto:alaskadentalgroup@alaska.net)

Patients Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone number: \_(\_\_\_\_)\_\_\_\_\_ email: \_\_\_\_\_

Please print the names of any dependents:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Any patient over 18 must sign for their own release)

- I authorize my records to be sent **TO** Alaska Dental Group from:

Name of Office: \_\_\_\_\_

Office Fax: \_(\_\_\_\_)\_\_\_\_\_ Office Phone: \_(\_\_\_\_)\_\_\_\_\_

Office Email: \_\_\_\_\_

- I authorize my records to be sent **FROM** Alaska Dental Group to:

Name of Office: \_\_\_\_\_

Office Fax: \_(\_\_\_\_)\_\_\_\_\_ Office Phone: \_(\_\_\_\_)\_\_\_\_\_

Office Email: \_\_\_\_\_

I am requesting the release of the following for each patient:

1. \_\_\_\_\_ All x-rays (By email)
2. \_\_\_\_\_ All treatment notes (by Fax or email)
3. \_\_\_\_\_ All periodontal charting (by Fax or email)

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date