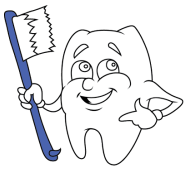

CHESTERFIELD
FAMILY DENTISTRY
Dr Jonathan W. Silva 314-878-9808
www.ChesterfieldFamilyDentistry.com
13463 Olive Blvd, Chesterfield, MO 63017

PATIENT RECORD RELEASE AND AUTHORIZATION TO CFD

Please e-mail or fax return this form to us @ frontdesk@chesterfieldfamilydentistry.com (preferred) or f: 314.878.9810

PATIENT:_____ DOB:_____

I hereby authorize: _____
(Past Providers Name)
to provide Chesterfield Family Dentistry with copies of my dental records with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me. This consent is effective until such date as I can cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Signed. _____ Date:_____
(Patient)

Signed. _____ Date:_____
(Parent, legal guardian, or POA of the patient, if patient is unable to sign for themselves)

Address to where physical records should be sent:

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ATTN: Dr. Jonathan Silva, DDS