Release of Information Form

Patient Name:

DOB:

Patient Signature:

Email / Mailing address to send records:

In accordance with the signed authorization and in response to a recent request, please find enclosed copies of dental records/xrays on the above named patient.

The enclosed information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the patient, to whome it pertains, or as otherwise permitted by law. A general authorization for the release of dental or other information is not sufficient for this purpose.

Please confidentially destroy the enclosed copies after the stated need has been fulfilled.

If you have any questions, please contact this office at the address or telephone listed.

Sincerely,

Edward J. Monroe, D.D.S.

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LaSalle, IL
61301

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