Record Access Consent Form

This document authorizes the following person(s) to have access to the dental/medical records of:

_____ _____/_____/_____
(Print patient name) (Date of birth)

This information includes but is not limited to making appointments for him/her and discussing information relating to his/her dental and medical condition with Dr. Theresa Robinson and authorized Staff.

Name: _____Relationship: _____

Address: _____Phone: _____

Name: _____Relationship:_____

Address: _____Phone: _____

Name: _____Relationship: _____

Address: _____Phone: _____

_____ _____
(Signature of patient) **(Date)**

_____ _____
(Witness) **(Date)**