NATHAN B. KLEIN, DDS, FAGD
PERSONALIZED DENTISTRY

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Release of Records

I, _____ hereby authorize Dr. Nathan Klein to release my dental records. These records may include x-rays, treatment notes, charting, medical and dental history, photographs, or other notations relevant to my treatment.
(Print Name)

These records may be released to: (Circle One)

1. My dentist / doctor: _____
   Address: _____
   _____
   Phone: _____

2. Sent to my home address: _____
   _____

3. Released to person authorized by me: _____

4. Personally picked up records.

_____ _____
Signature Date