Pennino Family Dentistry
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Barrington, Illinois 60010
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Authorization to release dental information

The execution of this form does not authorize the release of information other than that specifically described below:

To (Current Dentist): _____

Patient Name: _____

Date of Birth: _____

Release to: _____

I request and authorize the above named doctor or health care provider to release current images to the organization, agency, or individual named in this request.

Please check below the purpose or need for which information is to be used:

- ☐ Transfer of records
- ☐ Second Opinion
- ☐ Other: _____

Signature: _____ Date: _____