Authorization for Release of Dental Records

Patient:___________________________________ DOB:____________________________________

Patient:___________________________________ DOB:____________________________________

Patient:___________________________________ DOB:____________________________________

Patient:___________________________________ DOB:____________________________________

This letter is to authorize Alaska Premier Dental Group, LLC to obtain/release my dental records and/or x-rays. Our offices ***DO*** accept records and digital x-rays at the corresponding offices' email addresses.

Previous/New Dentist: ____

Address/City/State/Zip:____

Office Phone:________________________

Fax Number: ________________________ Email:________________________________

Patient/Guardian Signature:___________________________________ Date:______________________________

Reason for Request:____

Please Select one:

6611 Debarr Rd, Ste 100
Anchorage, AK 99504
Phone (907) 337-1322
Fax (907) 929-2178
akpremierdental100@gci.net

6611 Debarr Rd, Ste 200
Anchorage, AK 99504
Phone (907) 337-0404
Fax (907) 337-6086
akpremierdental@gci.net

865 N Seward Meridian PKWY
Ste 201 Wasilla, AK 99654
Phone (907) 373-5930
Fax (907) 373-7702
akpremierdental@mtaonline.net

For Office Use:

Staff Initials:________________________________

Date Records Emailed/Picked up/Mailed:____

Account Balance:________________________________

Approval for Release:____