The Oaks Dental Center, Ltd.

Agnieszka B Kumar, DDS
8600 US Highway 14, Suite 203
Crystal Lake, IL 60012
Phone: 815.356.0033 Fax 8153.356.0035
www.oaksdental.com

Authorization for Release of

Protected Health Information – Dental Record

1. **Patient Information:**

   Last Name _____ First Name _____ Date of birth _____

   Address & Phone _____

2. **Recipient Authorization:**

   I (patient name or representative) _____,
   do hereby authorize

   Name of the doctor or practice _____

   Address & Phone _____

   to release a copy of my dental record to

   The Oaks Dental Center, Ltd.
   8600 US Hwy 14, Suite 203
   Crystal Lake, IL 60012
   Phone: 815.356.0033
   Email: oaks@oaksdental.com
   Fax: 815.356.0035

3. **Information to be released:**

   ☐ Entire dental record ☐ Full-mouth series ☐ Panoramic x-ray
   ☐ Bite wings ☐ Individual x-ray

   _____ (signature) _____(date)

   _____ (print your name)

   If signed by anyone other than the patient, state the relationship to patient and/or legal authority for signing:

   _____