dental partners of Vero Beach

Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

Records Release Consent

Patients Name _____Date: _____

I, _____, authorize the following Doctor
(Patient/Guardian Name)

_____
(Doctor's Name)

_____ _____
(Phone) (FAX)

to request and forward records to the designated recipient.

Records Requested:

_____

_____

_____

Send records to:

❑ Name: Dental Partners of Vero Beach
Address: 3790 7th Terrace, Suite 201
Vero Beach, Fl. 32960
Phone: 772.569.4118 Fax: 772.569.9446
E Mail : Office@verobeachdentist.com

To forward my records to:

❑ Other Name: _____
Address: _____
_____
Phone: _____ Fax: _____
E Mail: _____

_____
(Patient or Patients Guardians Signature) 1/2024