



WISSLER • MYERS • KALLIES

FAMILY DENTISTRY

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CONSENT TO RELEASE RECORDS AND PERSONAL INFORMATION

Date _____

Name _____

DOB _____ SS# _____

I authorize Wissler, Myers & Kallies Family Dentistry, LLC to release information including dental records and/or radiographs for treatment rendered to the following practice

Practice Name _____

Address _____

Phone _____ and/or Fax _____

I have instructed Wissler, Myers and Kallies Family Dentistry to....

- Mail
- Fax
- Prepare for Pick-Up

Responsible Party Signature Date

Staff Member Signature Date