Authorization for Release of Dental Information and Records

I _____, authorize Dr. Barrineau, DDS to furnish
Print Name
Dental information and records concerning_____
Print Patient or Patients Name
To _____
Print Dentist Name & Address

Or

I _____, authorize _____to
Print Name Print Dentist Name
furnish Dr. Barrineau with all dental records concerning _____
Print Patient or Patients Name

Email records to: drnbarrineau@gmail.com
Or
By mail: 3404 Santa Rosa Dr. Gulf Breeze, FL 32563

I release and hold harmless Nicole B. Barrineau, DDS, members and employees, for liability, including for negligence, which may arise from complying with this authorization.

I understand that the dental record maintained by Nicole B. Barrineau, DDS might contain dental and administrative information from other healthcare providers. I understand that Nicole B. Barrineau, DDS is authorized by Florida law, to charge me for duplication costs incurred in connection with copying my dental records.

This authorization shall remain in effect for 1 year from the date below.

_____ _____
Signature Date

Relationship to Patient