2819 Dawson Street. Anchorage, AK 99503 Ph: 907-562-4774
Email: info@AlcanFamilyDental.com

Consent for Record Release

I, _____ hereby authorize _____

to discuss the following options about my treatment with the staff at Alcan Family Dental. With respect to any dental care or treatment, please select the following that can be shared with my designated parent, family member, legal guardian, or POA .

- ☐ Treatment Plan
- ☐ X-ray Records
- ☐ Appointment Scheduling
- ☐ Account Balance
- ☐ Insurance Information
- ☐ Dental History
- ☐ Health History
- ☐ Charting
- ☐ Personal information on file
- ☐ Other:

_____

This consent is effective until such date as I can cancel this consent. I understand that the information obtained because of this consent may be used after the cancellation date.

Signature:_____(Patient)

Signature:_____(Parent, Legal Guardian, POA of patient)

Date:

_____

You can email this form to info@AlcanFamilyDental.com