



Consent To Release Medical History

This authorizes Mobile Dentistry of Arizona to furnish any and all of the medical records, history and information

for _____ to _____
Patient Name New Provider/Doctor

This also includes x-ray films, past and current medications and any information, including opinions.

Patient Information

Patient Name: _____

Date of Birth: ___/___/___ SSN: _____ Marital Status: S M Other Sex: M F

Patient Living Address: _____
Street City State Zip Code

Patient Phone: _____ Patient Email Address: _____

Power of Attorney Information

POA Name: _____ Date of Birth: ___/___/___

POA Address: _____
Street City State Zip Code

POA Phone: _____ POA Email Address: _____

New Provider Information

Office: _____ Doctor Name: _____

Address: _____
Street City State Zip Code

Phone Number: _____ Fax Number: _____ Email: _____

➔ X _____
MUST BE SIGNED HERE Patient / Responsible Party / Power of Attorney Date