



Steven W. Baxter, DDS
Baxter Dental Associates, Inc.

5255 N. Maize Rd, Suite 109
Maize, KS 67101

Tel. (316) 773-6161
Fax (316) 773-6166

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date: _____

Address: _____

Phone Number: _____ Birth Date: _____

I hereby authorize _____ to release any diagnostic x-rays into my own keeping or to the following individual or organization.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

The facility, its employees and the attending dentist are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by this release. I am accepting responsibility for these records and for the protection of my own right of medical record confidentiality.

Signature of Patient

Date of Signature

Signature of Person Authorized to sign, other than Patient

Relationship to Patient