AMERICAN ACADEMY OF IMPLANT DENTISTRY
211 East Chicago Ave, Suite 1100, Chicago IL 60611-2616 312/335-1550

# AUTHORIZATION FOR RELEASE OF PATIENT RECORDS AND MATERIAL

_____
Doctor's Name

_____
Address

_____
City State Zip

You are hereby authorized to utilize and/or release all or portions of my dental records or other materials as prepared by you in connection with clinical evaluation, treatment and care, without limitation, for the purpose of sharing the same with other dental practitioners for demonstration, training or other professional scientific purpose.

_____
Witness

_____
Date

_____
Patient Signature

_____
Patient Name

_____
Address

_____
City State Zip

_____
Country

Return this form to the doctor named above.