# Release of Records

**Dr. Derek Haruta and Associates**
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DR.: _____ City: _____

Telephone: _____ Fax: _____

| | Name | Date of Birth |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |

I authorize your to furnish all dental records to Dr. Derek Haruta & Associates for the purpose of consolidating my dental history and records in one location and to facilitate future diagnosis & treatment.

| | 1. | 2. | 3. | 4. |
|---|---|---|---|---|
| **Bitewings** | | | | |
| **Panoramic** | | | | |
| **Complete Exam** | | | | |
| **Recall Exam** | | | | |
| **Scale, Polish & Root Planning** | | | | |

Please forward any other pertinent information. Thank you.

Patient/Guardian Signature _____ Date _____

Witness _____ Date _____