RECORDS RELEASE AUTHORITY

TO:_____ I, _____
Patient's Name

Hereby request that you release the following records and data pertinent to your treatment of me:

from _____ to _____

on to:

SOBHA ATANI, D.D.S.
831 CASS STREET
MONTEREY, CA 93940
Telephone: (831) 373-1279
Email: sobhaatanidds@gmail.com

Types of records requested (e.g. lab tests, specific records, summary of records, etc.)

_____

Pick one: ☐ Fax ☐ Paper Copy ☐ USPS ☐ Via encrypted email

☐ Via regular (unencrypted) email - I understand that there are possible risks due to the insecure nature of unencrypted email.

_____ _____
Patient's Date of Birth Signature of Patient, Parent, Guardian, or Personal Representative

_____ _____
Witness Please print name signed above

_____ _____
Date Relationship to Patient