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1630 Losey Blvd S
La Crosse, WI 54601
Phone: 608-782-7374
Fax: 608-782-4111

Authorization for Release of Records

Name of Patient____ Date of Birth_________________

I hereby consent to and authorize____ to disclose to:

Mooresmiles Dental
1630 Losey Boulevard South, La Crosse, WI 54601
e-mail: mooresmilesdds@gmail.com

information from my healthcare record relating to my identity, diagnosis, prognosis or treatment.

Information to be disclosed:
____ Health History Form (includes insurance, medical history, and medication information)

____ Diagnosis and therapeutic information (includes all examination and surgical records)

____ X-Rays (please send digital file in Dexis or jpg format to mooresmilesdds@gmail.com)

I understand that I have a right to inspect and receive a copy of the material that is disclosed as provided by the Wisconsin Administrative Code.

I understand that this consent is revocable. Unless revoked, this consent will expire 90 days from the date listed below.

Patient Signature____
Date________________

Parent/Legal Guardian____

Relationship to Patient____

Witness Signature____

NOTE: To ensure we provide comprehensive care for our patients, our office prefers to email digital radiographs and receive digital radiographs via email. Thank you.