Nathan W Schaffner, DDS
1337 Riverside Ave, St. 1
Fort Collins, CO 80524
(970)893-4998
staff@schaffnerfamilydental.com

# Dental Records Release Form

**Patient Name: _____ Date of Birth: _____**

Other Family Members to transfer**:**

_____

_____

_____

Please release dental records or copies thereof for the patient(s) listed above to the following Dental Office:

☐ **Schaffner Family Dental**
**1337 Riverside Ave, St. 1**
**Fort Collins, CO 80524**
**(970) 893-4998**
**staff@schaffnerfamilydental.com**

☐ **Office Name: _____**
**Address: _____**
**_____**
**Phone #: _____**
**Email: _____**

Reason for this authorization (check all that apply):
_____ At my request.

_____ Other: _____

I authorize the release of my confidential protected dental information, as described in my directions above. I understand that the release of these confidential records is at the discretion of the treating dentist.

**Patient/Guardian Signature: _____ Date:_____**