University Associates in Dentistry

Dental Implant Institute

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UAD UNIVERSITY ASSOCIATES IN DENTISTRY

# AUTHORIZATION FOR THE RELEASE OF PATIENT RECORDS

Patient Name(s): _____ Date: _____

_____

_____

_____

Address: _____

City: _____ St: _____ Zip: _____

Reason for transfer:

Records to be sent to:

Email digital xrays to: **uad@uadchicago.com**

University Associates in Dentistry
222 N. LaSalle St. #230
Chicago, IL 60601

_____
Patient's Signature

The following copies will be sent: (Office use only)

| | | |
|---|---|---|
| ☐Bitewings | ☐Full Mouth | ☐Panorex |
| ☐Ceph | ☐Dentition Charting | ☐Periodontal Charting |
| ☐Patient Documentation | ☐ CT scan | |

Authorized By: _____ Title: _____ Date: _____