Rodney K. Kihara, D.D.S.
1284 High Street
Auburn, Ca. 95603
530-888-1966 Fax: 530-888-1407

# Authorization for the Release of Dental Records

I hereby authorize Dr. Rodney K. Kihara, D.D.S to release the information in the

dental record of patient ______________________, to Dr. ______________________

address____________________________________________________________

phone________________________email____________________________________

Any and all information may be released including, but not limited to, dental health records, health history and x-rays.

This authorization is effective now and will remain in effec' . I understand that I may receive a copy of this authorization.

Patient Signature: ______________________________________________

Parent or Guardian Signature: ______________________________________

Patient Address: ________________________________________________

Patient Phone Number: ___________________________________________

Patient Email: __________________________________________________

Date: _________________________________________________________

- If not signed by the patient, please indicate relationship: ______________________

Scanned with CamScanner