Highland
Dental Center

16315 Mount Airy Rd
Shrewsbury, PA 17361
717-759-5063

Release of Information Form

Request Date: _____

Patient Name: _____

Patient Date of Birth: _____

Records to Release: _____

_____

_____

_____

_____

_____

_____

Reason for Release: _____

_____

_____

_____

I, the undersigned, hereby authorize Highland Dental Center to release the above-mentioned records for the above-mentioned patient to the following email (please print):

_____

Patient/Responsible Party Signature: _____

Date: _____