Pacific Coast Dentistry

Authorization for Treatment and Diagnosis
Release of Dental Records

I the undersigned do hereby authorize and consent to x-rays, examination, anesthetic, dental and surgical diagnostic procedures and/or treatment considered necessary.

I understand that if photographs, slides, and/or videos are taken, they will be used as a record of my care, and may be used for educational purposes and lectures, demonstrations, and professional publications.

I authorize Pacific Coast Dentistry to release any information acquired in the course of the examination.

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Signature of Patient/Parent/Guardian　　　　Date

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Witness　　　　Date

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Dr. Signature　　　　Date