A Health-Centered Practice
Renee TRUjillo, DDS

I, _____ authorize my previous dentist,
(print your full name)

Dr. _____

Dentist's address _____

City, State, Zip _____

Phone: _____ Fax:_____

to release any and all dental records to:

TRU Dental, PC
3849 Foothills Rd, Suite A, Las Cruces, NM 88011

Email: office@TRUdentalnm.com

This authority to release includes, but is not limited to: dental reports, clinical notes, doctor's notes, subjective and objective complaints, radiographs, any pertinent medical information, interpretations of a diagnostic test (including a copy of the report), diagnosis and prognosis, progress notes, prescription history, and any other document records or information in your possession relative to my past, present and future dental condition.

Please forward records for the following patients:

Full name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____

This authorization to release the information on the above named patient(s) is subject to the following statement. State law prohibits you from making further disclosure of such information without specific written consent of the person(s) to whom the information pertains or is otherwise permitted by state law.

Patient's Signature _____ Date _____

Patient's Address _____

City, State, Zip _____

Phone Number _____