Michael A. Sweeney DMD
New Heights Dental

Authorization to Release Dental Records

Patient Name_____ DOB_____

Previous Name if Applicable_____

I request and authorize _____
(Name of Previous Dentist)

Address_____ City_____ State_____ Zip_____

Phone #_____ Fax#_____

To release my dental information of the patient named above to:

Michael A Sweeney DMD
4111 Barbara Loop SE, Suite D2
Rio Rancho, NM 87124
Phone # (505) 892-8211

Please Email to: newheightsdentalnm@gmail.com

I understand that my express consent is required to release any dental care information relating to testing, diagnosis and treatment.

_____ _____
Signature of patient or patient's authorized representative Date

_____

State your relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.).