



AMERICAN ACADEMY OF IMPLANT DENTISTRY

211 East Chicago Ave, Chicago IL60611-2616

312/335-1550

**AUTHORIZATION FOR RELEASE OF PATIENT RECORDS AND MATERIAL**

\_\_\_\_\_  
Doctor's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

You are hereby authorized to utilize and/or release all or portions of my dental records or other materials as prepared by you in connection with clinical evaluation, treatment and care, without limitation, for the purpose of sharing the same with other dental practitioners for demonstration, training or other professional scientific purpose.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Country

**Return this form to the doctor named above.**