LI SOUND
DENTAL
SOLUTIONS

DAVID KAHN DMD

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CONSENT FOR RELEASE OF DENTAL RECORDS

Permission to obtain records

I, _____, with a date of birth, _____, give my permission for _____ to give my dental records to LI Sound Dental Solutions, the office of Dr. David Kahn, so that he can better understand my condition and help me.

I understand that:

- I do not have to grant my permission to share these records.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
- This form is only good for 3 months from the date I sign it.

_____ _____

Patient's (Guardian if a minor) signature Date