

*Family & Cosmetic Dentistry*  
Elaine K. Sours ♥ D.D.S., P.C.



**Patient Release of Information**

I authorize the Doctor and Staff of:

Elaine K. Sours, D.D.S., P.C.  
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To release any information contained in my dental records and any applicable dental radiographs that are current to my dental treatment history. Please send the requested information to:

Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Patient's Name: (Please Print) \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Signature \_\_\_\_\_

(Or parent/legal guardian if patient is a minor)

Date \_\_\_\_\_