Records Release Authorization

University Dental Associates Faculty Practice
PO Box 830740
40th & Holdrege, Room 2037
Lincoln, NE 68583-0740
402-472-8900 uda@unmc.edu

I, _____, hereby authorize and request University Dental Associates to release to:

Office Name: _____

Address: _____

City/State/Zip: _____

Phone/Email: _____

To complete medical history, records, and x-rays in its possession for:

Patients Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____

Signature: _____ Date: _____