Julie A. Veerman, DDS, LLC
3909 Arctic Blvd Ste 205 | Anchorage AK 99503 | 907.336.8772 voice | 907.563.8533 fax | email: staff@akdentspa.com

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

City, State, Zip: _____

Transferring records **IN** to our office
I authorize the following dental office to release patient records to Julie A. Veerman, DDS, LLC:

Doctor/Clinic Name _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Digital radiographs preferred via email

OR

Transferring records **OUT** of our office
I authorize Julie A. Veerman, DDS, LLC to release above patient's dental records to:

Doctor/Clinic Name _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Records are emailed whenever possible. Please be aware that **this email is unencrypted**.
If you **DO NOT** wish to have the records emailed, please initial here: _____

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing.
This authorization expires on _____ or three years from date of signature.

_____ _____
Signature of Patient or Patient's Personal Representative Date

If personal representative:

Print Name: _____Relationship to patient: _____