

**Boe, Page & Page Dental Group, PLLC  
4953 Castello Drive, Suite #100  
Naples, FL 34103  
239-263-2122**

**AUTHORIZATION TO OBTAIN PATIENT HEALTH INFORMATION RECORDS**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to release the following personal health information for: (check all that apply)

- Dental Treatment History
- X-rays (Full Mouth Series, Bite-wings, and PA's)
- Full Mouth Probe Charts

To: Boe, Page & Page Dental Group, PLLC  
4953 Castello Drive, Suite #100  
Naples, FL 34103

239-263-2122 (office) 239-262-5856 (fax)  
[frontdesk@thenaplesdentists.com](mailto:frontdesk@thenaplesdentists.com) (e-mail x-rays Dexis or JPEG)

The above information may be released by:

- Mail
- E-mail

**My Consent**

Effective: Today's Date \_\_\_\_\_

I want this consent to:

- Continue Indefinitely
- Effective Only Until \_\_\_\_\_(date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Or, Personal Representative \_\_\_\_\_ Date \_\_\_\_\_