



**MARKHAM**  
ORTHODONTICS  
David L. Markham, DDS, MSD

**Authorization for the Release of Dental Records**

*California*

**Date:** \_\_\_\_\_

I hereby authorize: (name of the dentist or dental office) \_\_\_\_\_ to  
release and receive the information in the dental records of:

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**Patient's name**

To:

**David L. Markham, DDS, MSD**

**T. 916.924.8970**

**F. 916.924.8988**

**Email to:** [business@markhamorthodontics.com](mailto:business@markhamorthodontics.com)

I recognize that email is not a secure form of communication. There is some risk that any individual's identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by unauthorized third parties.

or

**Mail to:**  
**Markham Orthodontics**  
**4110 Truxel Rd., Ste. 130**  
**Sacramento, CA 95834**

Any and all information may be released including, but not limited to x-rays, photos, intraoral pictures, and clinical notes.

This authorization is effective now and will remain in effect until

12/31/2030 (date)

I understand that I may receive a copy of this authorization.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

If not signed by the patient, please indicate the relationship:

Parent or guardian of a minor patient

Guardian or conservator of an incompetent patient

Beneficiary or personal representative of a deceased patient