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Records Release

I hereby authorize _____to release all of my personal dental records and any recent X-Rays. I also authorize you to release the additional family records member that I am authorized to sign for:

Name: _____ DOB _____
Name: _____ DOB _____
Name: _____ DOB _____
Name: _____ DOB _____

Please send records and x-ray's to:

Name : _____

Mailing Address _____
_____

Phone: _____

Email: _____

Dated this_____day of_____20_____

_____
Patient's Signature

_____
Printed Name