Dental Records Release Form

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I, ______________________________ authorize the release of records, including but not limited to, current dental x-rays, intra-oral photos and periodontal charting for the following;

Name: ______________________________ Date of Birth: ____________

Name: ______________________________ Date of Birth: ____________

Name: ______________________________ Date of Birth: ____________

Name: ______________________________ Date of Birth: ____________

FROM Dental Office: ______________________________

Address: ______________________________

Phone Number: ______________________________

E-mail Address: ______________________________

TO Dental Office: ______________________________

Address: ______________________________

Phone Number: ______________________________

E-mail Address: ______________________________

______________________________ ____________

Patient / Guardian Signature Date