Authorization to Release Dental Records
email: drdanielfrontdesk@yahoo.com

Patient Name: _____

I request and authorize the release of the information specified below to:

Name: _____

Address: _____

Phone: _____

Information Requested:

Copy of Dental X-Rays ____

Copy of Information in Dental Chart ____

Limited to Dates: _____

Purpose of Requesting Transfer of Records: _____

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

_____ _____

Patient Signature **Date**