AUTHORIZATION TO RELEASE DENTAL RADIOGRAPHS AND RECORDS

To Whom It May Concern,

I ___________________________________, hereby authorize and request Dr.________________________________ to send copies of all dental radiographs and summary of dental treatment records for patient(s),

____.

To Dr. ____

____
(address)

I hereby release Dr. _____________________________ from any liability related to disclosure of confidential or privileged information.

Signature:____

Address:____

Date:___________________________