AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

PATIENT: ______________________________________

DATE OF BIRTH: ________________________________

I, (print patient/guardian name) _____________________________________, hereby authorize the staff of Sterling Smiles Dental to release records or knowledge concerning my dental health to:

NAME: ____

ADDRESS: ______________________________________

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PHONE: ____

EMAIL: ____

I specifically request that you release copies of:

______ all x-rays ______ all treatment notes

PATIENT NAME: ____ DATE: __________________

PATIENT OR GUARDIAN SIGNATURE: ____