



Patient's Name _____ Date _____

Address _____

City _____ State _____ Zip _____

I hereby authorize release of my dental records and request that they be forwarded to:

Please forward:

Most current x-rays _____ FMX _____ Periapical XR of th# _____
Panorex _____ Perio Charting _____

Please allow 2 weeks to process these records.

PATIENT OR RESPONSIBLE PARTY _____ DATE _____