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Authorization to Release X-rays/Records

I, ______________________________ request the release of dental records relevant to dental treatment, or copies of such, and request that they **are transferred from:**

____

____

and forwarded to:

____

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Name of Patient:______________________________Date of Birth: ______________

Name of Patient: ______________________________Date of Birth: ______________

Name of Patient: ______________________________Date of Birth: ______________

Signature of Parent/Guardian: ______________________________Date: ______________

Please Email Records to: Info@PlymouthDentist.com

For Office Use Only

FMX: ______________ PAN: ______________

BWX: ______________ RECARE: ______________

SPOKE W/: ______________ DATE: ______________

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