

**Garrett S. Dennis D.M.D.**

**AUTHORIZATION FOR RELEASE  
AND TRANSFER OF DENTAL RECORDS**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize the office of Garrett S. Dennis to release my dental record and all of its entities, listed below, to the above named dental office.

Information requested:

- \_\_\_ Copy of Complete Dental Chart
- \_\_\_ Copy of current x-rays including FMX/Pano/BWX
- \_\_\_ Other (specify)

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Date of Birth