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AUTHORIZATION FOR RELEASE AND TRANSFER OF DENTAL RECORDS

To: _____

_____

_____

Phone: _____

I, _____, hereby authorize the office of Garrett S. Dennis, D.M.D. to request and receive my dental record and all of its entities, listed below, from the above named dental office. Please send in Dexis format.

Information requested:

____ Copy of Complete Dental Chart

____ Copy of current x-rays including FMX/Pano/BWX

____ Other (specify)

*Please email information

_____ _____
Signature of Patient/Parent/Guardian Date

_____
Patient Date of Birth