

# AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

## WATER'S EDGE FAMILY & COSMETIC DENTISTRY

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To: \_\_\_\_\_  
(Previous Dentist's Name)

Address: \_\_\_\_\_  
\_\_\_\_\_

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

Please release all dental records including x-rays for:

\_\_\_\_\_  
Patient's Last Name                      First                      Middle Initial

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

I hereby authorize the release of all my dental records and take full responsibility.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date