Water's Edge Dentistry

# Authorization for Release of Dental Records


**Water's Edge Family & Cosmetic Dentistry**
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Send To: _____
(Dentist's Name)

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

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