Dental Records and Radiograph Release Form

I, (print patient or guardian name) _____, hereby authorize the doctors and staff to release records, radiographs or knowledge concerning my dental health to (select one):

_____ 1. Given directly to me

_____ 2. Sent directly to a dental office

Name of Dental Practice: _____

Address: _____

Telephone Number: _____

Fax Number: _____ Email: _____

_____ 3. Given to a guardian (if patient is a minor)

Please complete this form and bring it to our office or fax it to (248) 626-6489.

You may pick up the records from our office. Please call to ensure the records were duplicated.

Upon request, the records can be mailed to your new dentist.

_____ _____

Patient Signature Date

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