the RENO dentist

Authorization for Release of Dental Records

Today's Date: _____

Patient(s) Name and Date of Birth: _____

Requesting: Treatment Notes _____ Perio Charting _____ Bitewing X-rays _____ Pano _____

Records to be: Emailed _____ Mailed _____ Picked up _____ on _____

Reason for Request: Quality of Service ___ Cost___ Billing Problems ___ Seeing another dentist ___ Relocating __

I authorize the **REQUEST** of my records from:

Dr.'s Name: _____

Phone#: _____

Address: _____

Email: _____

I authorize the **RELEASE** of my records to:

Dr.'s Name: _____

Phone#: _____

Address: _____

Email: _____

Signature of Patient or Guardian_____

Team Member initials _____ Date records sent/picked up_____

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