AUTHORIZATION TO RELEASE RADIOGRAPHS/ DENTAL INFORMATION

Patient's Name: ________________ Date of Birth: ________________

Address: ________________ Phone #: ________________

I request and authorize **Lexington Smile Studio** ________________ to release dental care information of the patient named above to:

Name: ________________

Address: ________________

City: ________________ State: ________ Zip Code: ________

EMAIL: ________________ Tel: ________________

Fax: ________________ Doctor : ________________

This request and authorization applies to:

□ Dental Records relating to the following treatment, condition, or dates: ________________

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□ All Dental Records including Radiographs.

□ Other: ________________

□ Yes □ No I authorize the release of any records regarding my medical/dental history.

Patient Signature: ________________ Date Signed: ________________