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DAVENPORT Dental
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Release of Records

I _____, authorize Dr._____ to release x-rays and or details of my treatment and/or that of my family to:

Dr._____

Please provide the following information to assist in a smooth patient transition.

Date of New Patient Examination: _____

Date of last Recall Examination: _____

Date of last Bitewing X-Rays: _____

Date of last Panorex X-Rays: _____

Names of additional family members whose x-rays and information are to be released:

_____ _____

_____ _____

I release you from all legal responsibility or liability that may arise from this authorization.

Sincerely, _____

DATE: _____

WITNESS: _____