CARP FAMILY DENTISTRY

RELEASE OF RECORDS AUTHORIZATION

I, _____, authorize _____ to release my dental records including my most recent bitewing radiographs, panorex and any other information that may be diagnostically relevant to Carp Family Dentistry for the continuation of my treatment.

Date:

Patient Name:

Patient Signature:

Previous Dentist's Phone/Fax #

FOR OFFICE USE:

Last NPX:

Last RC:

Last Pan:

Last BW: