Rochester Family Dentistry

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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I,_____**(D.O.B.**_____**)**

authorize:_____

_____

_____

Dentistry to release the following dental information to:

Rochester Family Dentistry
310 W. University Drive
Rochester, MI 48307

Please email all digital x-rays to:
info@rochesterfamilydentistry.com
Thank You!

_____**Full Mouth Xrays/PANO**

_____**Bite Wing Xrays**

_____**Perio Chart**

This information is being released for the following purpose(s) only:

_____

_____

This release is effective for six months from the date of execution, however it may be revoked by me at any time by providing notice in writing to the above named party.

_____**Date**_____
Patient/Legal Guardian of Patient

_____**Date**_____
Witness