GROVETOWN
FAMILY DENTAL

Authorization for Release of Dental Records

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

Address: _____

_____

- ☐ **I authorize Grovetown Family Dental to release my records to the dental practice below:**
- ☐ **Please have the dental practice below release my x-rays and records to Grovetown Family Dental.**
- ☐ **Please have previous dental office email x-ray's to: grovetownfamilydental@aol.com**

Dr./Practice Name: _____

Address: _____

_____

Phone #: _____ Fax#: _____

Email address: _____

Reason for request:

___ Moving ___Other (please explain) _____

_____

Patient/Guardian Signature