Mowry Dental

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Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby authorize the doctors and staff of Mowry Dental to release records or knowledge concerning my dental health to:

Full Dr. Name: _____

Street Address: _____

City, Zip Code: _____

Practice telephone number: _____

I specifically request that you release copies of:

All x-rays all treatment notes

Signed (patient or guardian name): _____

Printed Name (patient or guardian name): _____

Please complete this form and fax it to (510) 952-4323. Payment is required to cover the cost of duplication and/or copying patient records.