Date ________/________/________

## Authorization for Release of Dental Records and X-rays

I ______________________________________, hereby authorize the release of records
(print patient or guardian name)

concerning ______________________________ dental health and copies of all x-rays.
(patient name (s)

Patient's D.O.B.________________________________

Previous Dental Provider:

Doctor's Name: ____________________________________________________________

Street Address: ____________________________________________________________

City, State, Zip ____________________________________________________________

Phone: Email

Please forward to:
Yellow Springs Dental
2100 Old Farm Drive Suite 1F
Frederick, MD 21702
301-663-1700

Signed Patient or Guardian ________________________________________