Release of Records

I, ____________________ hereby authorize Dr. Robert G. Java to release my dental records. These records may include x-rays, treatment notes, charting, medical and dental history, photographs, or other notations relevant to my treatment.

These records may be released to: (circle one)

1. My dentist/doctor: ______________________________

   E-MAIL: ______________________________

   Address: ______________________________

   ____

   Phone #: ______________________________

2. Myself

   E-MAIL: ______________________________

   Address: ______________________________

   ____

   Phone #: ______________________________

_______________________________ ______________________

Signature Date