Authorization to Release Dental Records

I, ____ DOB: ______________

authorize Cities Dental Studio to transfer the following records:

___ Radiographs (PA/BW/FMX/Panoramic)

___ Chart Notes

___ Treatment Records

___ Other

TO:

Name: ____

Address: ____

Phone: ____

**e-mail: ____

Additional Family Members:

____ DOB: ______________

____ DOB: ______________

____ DOB: ______________

Printed Name: ____

Signature: ____

Date: ____

*Please allow 5-7 business days to complete all transfer requests
There will be a $25 processing fee for all records other than most recent radiographs and clinical notes

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