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# Authorization for Release of Dental Records & Radiographs

I, ____________________________________, request all current radiographs and/or chart
(Patient/Guardian)

copies are released for: ________________________________________.
(Patient's Name)

Patient's date of birth: ________________________________________.

Select how you would like us to send/receive your records (email is fastest)

**For incoming records**:

_____ 1. Mail directly to Sheldon Family Dental (please see address above)

_____ 2. Email to: sheldonfamilydental@gmail.com

_____ 3. To be picked up by: _________________________________

**For outgoing records**:

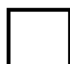
_____ 1. Please mail to the following address:

____________________________________________________
____________________________________________________
____________________________________________________

_____ 2. Email to: ________________________________________

_____ 4. To be picked up by: _________________________________

Signature of patient/guardian: ______________________________ (type)
Date: ______________________________



BY CHECKING THIS BOX, I ACKNOWLEDGE USE OF MY ELECTRONIC SIGNATURE