Authorization for Release of Dental Records and X-rays

I, <<patient_full_name>>, hereby authorize the office of _____ (former dentist) to release dental records and x-rays for myself and/or my family members.

(Please list family members here.)

_____ Signature (if over 18) _____

_____ Signature (if over 18) _____

_____ Signature (if over 18) _____

_____ Signature (if over 18) _____

_____ Signature (if over 18) _____

Please forward our records to:

jen@nittanydental.com

or mail to:

Nittany Dental Associates
2601 Gateway Drive
Suite 250
State College, PA 16801

Phone (814) 238-0088
Fax (814) 238-0081

_____
Signature of <<patient_full_name>>