Dear Dr. _____
_____
_____
_____

Records Release Authorization

I hereby authorize and consent to my dentist to obtain copies of my medical and dental records from current or past dentists, physicians, psychologist, specialist, hospital, or any other medical/dental care provider.

I authorize any health care provider who has treated me to discuss my care and treatment with my dentist. This authorization shall be valid until withdrawn by me, in writing.

Please release any **x-rays and records** to:

Powell Dental Group
Shelley D. Shults, R.N., D.D.S.
39 Clairedan Drive
Powell, OH 43065
(614)436-4433
Fax (614)436-6055
frontdesk@powelldentalgroup.com

_____ _____
Patient/Parent/Guardian Signature Date

Patient(s) Printed Name: _____ DOB_____

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB_____