ABQ DENTISTS

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Authorization for Release of Dental Records and X-Rays

I, (print patient or guardian name) ______________________________, herby authorize the doctors and staff of:

Name:______________________________________

Address:____________________________________

Phone#:____________________________________

Email:______________________________________

To release my records or knowledge concerning my dental health to:

ABQ DENTISTS
3900 Eubank Blvd NE St 14
ABQ, NM 87111
Email: abq.dentists@yahoo.com

**X-Rays **Periodontal Charting **Treatment Notes

Other Family Members:____

Signature: (patient or guardian)__________________________________ Date:______________

Printed Name: (patient or guardian)______________________________