Dallas Center for Oral Health and Wellness

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Authorization for Release of Dental X-rays and Records

I, (print patient or guardian name) _____,

hereby authorize the doctor and staff of Dallas Center for Oral Health & Wellness, PLLC to release dental records including x-rays to:

Dr. Name or Facility Name: _____

Address: _____

Tel. Number: _____

Fax Number: _____

Email: _____

Signed (patient or guardian name) _____

Printed name (patient or guardian name) _____

Date _____

Please complete this form and fax it to (972) 566-6401 or mail to our office at the above address.