Authorization for Release of Dental X-rays and Records

I, (print patient or guardian name) _____,

hereby authorize the doctor and staff of Dr. _____ to release dental records including x-rays to:

Dallas Center for Oral Health and Wellness

Dr. Anna Willison and Dr. Eugene Dahl

7777 Forest Lane, Suite A-309

Dallas, TX 75230

Phone (972) 566-6300 Fax (972) 566-6401

Email- info@yourprettysmile.com

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.