AUTHORIZATION FOR RELEASE OF FAMILY RECORDS

DATE:_____

PATIENT NAME:_____
DATE OF BIRTH:_____

PATIENT NAME:_____
DATE OF BIRTH:_____

PATIENT NAME:_____
DATE OF BIRTH:_____

PATIENT NAME:_____
DATE OF BIRTH:_____

I authorize the release of dental records and radiographs relevant to dental treatment or copies of such, and request that they are emailed or mailed to:

Joseph A. Savoini D.M.D., P.C
1231 Willow Creek Road Suite A
Prescott, AZ 86301
Phone: 928-778-5518
savoinidental@hotmail.com
Fax: 928-541-9640

(please send x-rays in *.jpg format; thank you)

*Patient's over 18 signatures and/or responsible guardian:

*_____
*_____
*_____
*_____

Prior doctor's office:_____

Phone #:_____