AUTHORIZATION FOR RELEASE OF RECORDS

DATE:_____

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 or Guardian Signature:_____**

Prior Dental Office:_____

Prior Dental Office Phone #:_____

Prior Dental Office FAX#:_____