Westside Family Dentistry

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Release of Dental/Medical Records

I, undersigned, authorize any dentist, physician, health care provider, hospital or other facility to release any dental/medical records, laboratory reports, x-rays, other imaging and/ or reports to the individual listed below.

A copy of this may be used in lieu of an original.

Printed Name: _____

Signature (or parent/guardian if a minor)

_____ Date _____

I authorize my records to be released to:

☑ Myself

☐ Other

Name: _____

Address: _____

_____Phone#:_____

Email: _____

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