Authorization for Release of Dental Records and X-rays

I ___________________________________ hereby authorize the

doctors and staff of **Dental Arts of Avon, P.C.** to release records or knowledge concerning my/my child's dental health to:

Doctor or Practice name ____

Street Address ____

City, Zip Code ____

Practice telephone number ____

Please state your reason for transfer:

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Patient's Name:____________________________________

Signature ___________________________ **Date:**__________________

Print Name _________________________ **Relationship to Patient:**______________