SPECIALISTS
IN IMPLANT DENTISTRY

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AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

I hereby authorize and request the release of copies of the complete dental history, records, treatment notes and radiographs in your possession concerning my past to present dental treatment from:

_____
Name of previous **dental** office

I hereby authorize and request the release of copies of my medical history, specifically list of medical conditions, most current list of prescription medicines, and surgeries/procedures in the last 5 years from:

_____
Name of **medical** doctor's office

_____ _____
Signature of Patient/Authorized Representative Date

Please email records to: implantsnaples@gmail.com. Please send dental x-rays in JPEG format. Thank you.