PATIENT RELEASE FORM

DATE: _____

I _____ hereby authorize _____
(Patient Name in block letters) (Name of Current Dental Office)

to provide **DENTISTRY AT DIPIETRO** with copies of my dental records with respect to any dental care and treatment I have received. Kindly send the information via email to info@dentistryatdipietro.com

Date of latest New Patient Exam: _____

Date of latest Hygiene Visit: _____

Date of latest Pan X ray: _____

Date of latest Bite Wing X Ray: _____

OTHER DETAILS : _____

THANK YOU

SIGNATURE OF PATIENT: _____

SIGNATURE OF PARENT/GUARDIAN: _____