Records Release/Request

To: _____
(Doctor)

Address: _____

City: _____State_____Zip_____

I hereby authorize the release of my dental records, or copies of such, including a full set of x-rays or Panorex taken within the past 5 years, and any and all checkup x-rays taken within the past 1 year, and request that they be transferred.

David G. Kardynal, D.D.S., P.C.
48635 Hayes Rd.
Shelby twp., MI 48315

_____
Print Name of Patient

_____
Patient Signature Date