Taylor Family Dental
+1 (303) 838-0311 info@taylorfamilydental.com

Authorization to Release Dental Records

I, _____,

with date of birth _____,

authorize my previous dentist _____

located at (Address, City, State, Zip Code) _____

& with Phone Number _____

to release my dental records to:

Taylor Family Dental
460 County Road 43, Suite 3
(303) 838-0311
info@taylorfamilydental.com

Patient/Guardian Signature:

_____

Date: _____