Cosimi Dental Implants and Periodontics

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Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby

authorize the doctors and staff of *Cosimi Dental Implants and Periodontics* to release records or

knowledge concerning my dental health to:

Name _____

Street Address _____

City, Zip Code _____

Telephone number: _____ Fax #:_____

Email:_____

I specifically request that you release copies of:

☐ x-rays ☐ treatment notes

Signature (patient or guardian name) _____

Printed name (patient or guardian name)_____