I hereby authorize _____to release the dental records of the patients listed below to Lori J. Engelmann, DDS and dental133.

Patient Name: _____ Date of Birth: _____

Records Requested: X-rays Perio Chart Treatment Notes

Signature (parent if minor): _____ Date: _____

Patient Name: _____ Date of Birth: _____

Records Requested: X-rays Perio Chart Treatment Notes

Signature (parent if minor): _____ Date: _____

Patient Name: _____ Date of Birth: _____

Records Requested: X-rays Perio Chart Treatment Notes

Signature (parent if minor): _____ Date: _____

Patient Name: _____ Date of Birth: _____

Records Requested: X-rays Perio Chart Treatment Notes

Signature (parent if minor): _____ Date: _____

Please send records to:

Lori J. Engelmann, DDS
4300 West 133rd St, Suite 100
Leawood, KS 66209
Phone: 913-451-0006

Digital Records may be securely emailed to:

info@dental133.com