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Authorization for Release of Records to Apex Family Dentistry

I do hereby authorize _____ and/or staff to disclose my dental records to Apex Family Dentistry, including current and previous dental records from another practitioner(s)/clinic(s) which are part of my dental record. If additional consent is necessary from person authorized to give consent, other than the patient, such as a guardian, etc., that signature is also given below.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Patient/Parent/Guardian Signature Today's Date

Please send digital x-rays/records to: info@apexfamilydentistry.com

Please mail or fax paper records to the address listed at the top of this request.

Last Bitewing X-rays taken on: _____ Last Panorex/FMX take on: _____

Last Recall: _____ Date(s) of Periodontal Treatment: _____

Outstanding Treatment or Areas of Concern:

_____

_____