Release of Dental Records

I, _____ do hereby authorize the release of dental records for the following family members:

_____

_____

_____

_____

For the following reason:

_____

From office name and/or Doctor Name: _____

Phone#_____**Fax#**_____**Email**_____

Please email: X rays, FMX, PANO and Periodontal History

I wish to have the records sent to:

Warner Center Dental

6400 Canoga Avenue Suite #180

Woodland Hills, CA 91367-2463

Email: info@wcdental.com

Phone: 818-887-2880 Fax: 818-887-2644

_____

Signature Date

_____

Patient phone number