

## Release of Dental Records

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

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For the following reason:

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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