

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