DENTAL ARTS CENTER
Jonathan E. Beaugez, D.M.D.
IMPLANTS.GENERAL.COSMETIC

RECORDS RELEASE FORM

Patient Name: ____ Birth Date: _____ _____ _____
Last First mm/dd/yyyy

Address: ____

City:_____________________________ State: _________________ Phone: _____________________

THIS IS TO AUTHORIZE THE RELEASE OF MOST CURRENT DENTAL RECORDS INCLUDING X-RAYS AND PERIODONTAL CHARTING.

FROM:

Dentist Name: ____

Address: ____

City: ____________________ State: ______________ Phone: ___________________

TO:

Dentist Name: ____

Address: ____

City: ____________________ State: ______________ Phone: ___________________

By checking this box ☐ and signing below, I consent to the release of my most current dental records including X-rays obtained in the course of my diagnosis and treatment from any Dentist who has attended me at any time concerning my past, present, or future dental treatment.

DATE: __________________ **SIGNATURE:** ________________________