Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name)_____, hereby authorize the doctor and staff of _____ to release dental records or x-rays or knowledge concerning my dental health to:

____ Send to the below named office:

Name of Dental Practice: Wong Family Dentistry
2970 Hilltop Mall Road, Suite 212
Richmond, CA 94806

Email Address: wongsdental@gmail.com

Phone number: 510-222-4178

Fax number: 510-222-8677

____ Send to patient or guardian

Email Address: _____

I understand that I may receive a copy of this authorization.

I understand and agree to pay a reasonable charge to cover the cost of the transfer based on your office's fee. If there is any fee please inform me before process.

Signed: _____

Printed Name:_____

Date: _____

Signed (patient or guardian name):_____