Alamance Family
DENTISTRY
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Authorization for Release of Dental Records & Radiographs

I, _____, request all current radiographs and/or chart
(Patient/Guardian)

copies are released for: _____.
(Patient's Name)

Patient's date of birth: _____.

_____ 1. Please mail to the following address:

_____

_____

_____

_____

_____ 2. Mail directly to Alamance Family Dentistry (please see address above)

_____ 3. Email to: info@alamancefamilydentistry.com

_____ 4. To be picked up by: _____

Signature of patient/guardian: _____

Date: _____

Thank You!