

AZ FAMILY DENTISTRY

5690 W. Chandler Blvd., Suite 1

Chandler, AZ 85225

PH: (480)753-1111

Fax: (480)763-1112

Authorization to Release Dental Information

Patients Name: _____

Patients Date of Birth: _____

I, _____ authorize AZ Family Dentistry to release a **copy** of x-rays or dental records:

Name and Address to send x-rays to: _____ _____ _____ _____

Patient Signature (Parent or Legal Guardian, if patient is a minor)

Today's Date: