Dr Jeffrey Baumrind
Dental Record Release Form

Patient's Name _____
Social Security Number _____
Date Of Birth _____
Providers Name _____

I Hereby authorize that my dental records be released to:

Dr. _____
Address _____
_____
Telephone # _____

Portion of record to be released

Entire Dental Record ____
X -Rays ____
Other ____ Describe _____

_____ _____
Signature of patient or guardian Date

Fax # 404-659-7616
Email drbaumrind@drbaumrind.com