# Dental Record Release Form

Patient's Full Name ___________________________________

Date of Birth: _____/_____/______

**I hereby authorize that my dental records be released from __________________ to:**

Dr. ____________________________

Phone: (        )_____-_________

Email: ___________________________________________

Fax: (        )_____-_________

**Portion of Record to be Released:**

Entire Dental Record ☐

X-Ray ☐

Other ☐

_________________________________ ______________
**Signature of Patient** **Date**

E-Mail: info@drbaumrind.com
Telephone Number: (404)659-4222
Fax Number: (404)659-7616