RECORDS RELEASE AUTHORIZATION

To:

_____

_____

_____

I hereby authorize and request that you release copies of my current x-rays and treatment information to:

Cheryl Larson, D.D. S.
294 N Nelson Rd.
Ludington, Mi. 49431
Fax: 231-425-3628
Email: clarsondds@gmail.com

Please complete information regarding their dental history.

Last Exam_____

Last Pan_____

Last B/W_____

Perio History_____

Areas being observed_____

_____

Thank you for taking time to assist in your patient's continual care.

_____
Cheryl Larson, D.D.S.

_____
Patients Name

_____ _____
Patients Signature Date

_____
Patients Address