



RECORD RELEASE FORM

Date: _____

Patient Name: _____

I, _____, authorize Dr. _____ to release radiographs and/or records to Dr. Amaro as I am now a patient of their practice.

The Radiographs are for Myself and/or my family NAMES _____

Please also include date of the last visit for the following procedures:

Complete Exam _____ Pan/Fms _____

Recall Exam _____ # BW's _____

Hygiene _____

Thank you for your prompt attention to this request.

Signature of Patient