Radiographs and Records Release Request

Date: _____

To: _____

Address: _____

City: _____ Fax: _____

I authorize the release of dental records, medical records and radiographs relevant to dental treatment, or copies of such, and request that they are transferred to:

Joe W. Potter, D.D.S., P.A.
Brandon K. Florence, D.D.S.

207 W. Belt Line Road
P. O. Box 390
Cedar Hill, TX 75106

Office
972-291-1501

Fax:
972-291-1503

_____
(Print Name of Patient)

_____
(Signature of patient, parent)