RELEASE OF RECORDS

I, ________________________________ (DoB: / /) patient of record, request current dental x-rays, including PANORAMIC, FULL MOUTH, PERIAPICAL or BITEWING films that may be available and any other vital information be sent to the following:

NAME: ORO VALLEY DENTAL ARTS

ADDRESS: 9000 N. Oracle Road Building A
Oro Valley, AZ 85704

PHONE: (520) 297-2007

FAX: (520) 297-2008

E-MAIL: office@orovalleydentalarts.com

The above mentioned patient(s) authorize the release of these current records.

Patient Signature:__________________________________ **Date:**______________________

PREVIOUS DENTAL OFFICE INFORMATION:

OFFICE NAME: ____

OFFICE ADDRESS: ____

____

OFFICE PHONE: ____

OFFICE EMAIL: ____