PLEASE FORWARD THIS XRAY RELEASE FORM TO YOUR PREVIOUS DENTIST

RECORDS RELEASE AUTHORIZATION

To: _____

Doctor or Hospital

_____

Address

I hereby authorize and request you to release to :

Levitt & Zugner Dental Group
55 North Avenue
Webster, New York 14580

the complete history records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Name: _____ Date: _____

Address: _____

Signature: _____

(If relative, state relationship)

DATE OF MOST RECENT: bitewing x-rays _____ full-mouth/panoramic _____

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