Alaska Center for Dentistry, PC

Authorization for Release of Dental Records

Patient:_____ DOB:_____

Patient:_____ DOB:_____

Patient:_____DOB:_____

I authorize Alaska Center for Dentistry, PC to obtain/release(circle) my dental records and/or xrays.

Previous/New Dentist(circle):_____

Address/City/State/Zip:_____

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Phone:_____ Fax:_____

Email:_____

Patient/Guardian Signature:

_____Date:_____

Reason for Request:_____

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Email: contact.wasilla@alaskacenterfordentistry.com