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 x-rays.

Previous/New Dentist (circle):_____

Address/City/State/Zip:_____

Phone:_____ Fax:_____

Email:_____

Patient/Guardian Signature:_____ Date:_____

Reason for Request:_____

Alaska Center for Dentistry, PC
1700 E Bogard Rd. Suite 201A
Wasilla, AK 99654
Phone: (907) 373-8455
Fax: (907) 373-8456
Email: contact@acdwasilla.com