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Authorization For Release Of Dental Records

To: Dr. _____

Address: _____

City: _____

Phone Number: _____

Fax Number: _____

I hereby authorize you to transfer my / our dental records and associated radiographs to the office of Dr. Rosanna Porretta, and/or Dr. Xhillari.

Kindly provide the following information:

Date of initial examination: _____
Last recall examination: _____
Last scaling / polishing: _____
Last BW's, Panorex, FMS: _____

Any other pertinent information they may require including pending treatment, etc. Thank you for your co-operation in this matter.

Patient Name(s): _____

Signature: _____

Date: _____