AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby authorize the release of my dental x-rays to the dental office of:

Miranda & Ortega, D.M.D., P.A.
1298 N. Dixie Freeway
New Smyrna Beach, FL 32168
Telephone: 386-428-2958
Email: mirandaandortega@yahoo.com

Patient's Name:_____Date of Birth:_____

Patient Signature: _____Date _____

(Parent or legal guardian must sign if patient is a minor.)

Previous Dentist Information:

Name:_____

Address:_____

_____

Telephone:_____

Email:_____