AURENTZ
FAMILY DENTAL

RECORDS AND XRAY RELEASE REQUEST

Date:_____

I, _____(Parent/Guardian) of

_____(Child/Children) Authorize the release of dental, medical records and xrays relevant to dental Treatment, or copies/duplications of such, and request they be transferred to:

Dentist's Name_____

Address_____

City/State/Zip Code_____

We charge a $25 non-refundable duplication fee. Release of records will take 2-3 weeks to be sent to new provider. Account balance must be at zero before records/xrays can be released.

Signature of
Parent/Guardian_____Date_____

Printed Name of Parent/Guardian_____

Relationship_____

3140 Horizon Road STE 103, Rockwall TX 75032 ● Phone 469.651.1776 ● Fax 469.651.1779

www.aurentzdental.com