Laura O. Taylor DMD

Records Release

Previous Dentist Name: ____ Fax: _____________________

I __________________________________ hereby give my consent to release any current dental radiographs (Fully Mouth Series, Panoramic within 5 years and/or Bitewings within 1 year), and summary record for the patient(s) listed below.

Patient Name: __________________________________ DOB: __________________

Patient Name: __________________________________ DOB: __________________

Patient Name: __________________________________ DOB: __________________

Patient Name: __________________________________ DOB: __________________

Please provide the requested information to the office listed below:

Office Name: ____

Office Phone: ____

Office E-mail: ____

Patient Signature: ____ Date: _______________