Authorization to Release Dental Records

I, _____ hereby request that Dr. _____ at _____ release a copy of my dental records and any current x-rays to the dental office of:

Buehler Family Dental
Christin Buehler D.D.S
912 W. Main Street, STE 404
New Holland, PA 17557
Phone (717) 656-0005
Fax (717) 656-2406
Email:info@buehlerfamilydental.com

Patient's Name _____

Date of Birth _____

Patient Signature _____ Date _____

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