

RADIOGRAPHS AND RECORDS RELEASE REQUEST

Date: _____

To: _____
(Doctor)

Address: _____

City: _____ Fax#: _____

I authorize the release of dental records, medical records, and radiographs relevant to dental treatment, or copies of such, and request that they are transferred to:

**Brandon K. Florence, D.D.S. P.L.L.C.
Joe W. Potter D.D.S. P.A.
(207 W. Belt Line Rd.)
P.O. Box 3098
Cedar Hill, TX. 75106
972-291-1501
Fax#: 972-291-1503**

(Print name of patient)

(Signature of patient, parent or legal guardian)

Number of pages including this one: _____