Authorization to Release Records

Since a patient's dental records are confidential, your written authorization will allow your previous dentist to release them to another dentist or party you designate.

Today's Date:______________________________

Patient's Name:______________________________

Address:______________________________

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Previous Dentist:______________________________

Address:______________________________

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Phone Number:______________**Fax Number:**______________

I authorize you to transfer and or copy dental records on the following person(s)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Sign: ______________________________

Please send x-rays in a jpg format & email to wismanndental@gmail.com

Please mail to: Enrique Wismann, D.M.D.

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Offi ce: 623-566-6478 Fax: 623-566-7241