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General, Cosmetic and Restorative Dentistry

Charles & Linda Steel, DDS, PA

Records Release

I hereby authorize the office of Charles & Linda Steel, DDS, PA. To furnish requested information and radiographic (x-ray) records of dental treatment for:

____
Name of Patient

To the following individual, office or assigned representative:

Name: ______________________________

Address : ______________________________

____

I understand that the office of Charles & Linda Steel, DDS, PA will make every effort to facilitate this transfer of information and will retain the original records.

____
Signature of patient, parent, guardian or legal representative *Date*

____
Print or Type Name

Accredited Cosmetic Dentists