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301-963-0800

Authorization for Release of Dental Records

To: _____
Previous Dentist's Name

_____
office phone number

_____
office fax number

Re: _____
Patient's Name

Patient Date of Birth _____

Dear Doctor:

Please e-mail a copy of my dental records and X-rays to:

admin@gladnickdentistry.com

If you have any questions or concerns, please call Gladnick Family and Cosmetic Dentistry at (301) 963-0800.

Thank you for your cooperation and time.

_____ _____
Patient Signature Date