SOUTHERN FAMILY
DENTAL GROUP

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Fax: (912) 764-2417
www.southernfamilydentalgroup.com

Authorization for Release of Medical Records

Patient information (Please Print):

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

RELEASE MY RECORDS FROM

Name: _____

Phone: _____

Fax: _____

Email: info@southernfamilydentalgroup.com

Please release a copy of my dental records, including but not limited to, progress notes, x-ray films, and diagnostic records.

By my signature, I authorize the release of my dental records.

Patient/Guardian signature: _____ Date: _____