Release of Records Authorization

I hereby request and give authorization to Dr. ________________________________

____
Address

____
City, State Zip

____
Phone

to provide copies of all my records (including current xrays) to:

Rockside Family Dental Care
6132 West Creek Road
Independence, OH 44131
(216)524-8481
info@rocksidedental.com

Records may be mailed or emailed to the contact information listed above.

________________________	________________________	____________
Signature (Parent, Legal Guardian or Custodian of patient if patient is a minor)	Printed Name	Date