3900 Fifth Avenue Suite 270
San Diego, CA 92103
619-810-1864

Authorization for Release of Dental Records and X-Rays

Patient Name: _____

Date of birth:_____

Release Records to:_____

_____

_____

Information requested:

____ Copy of dental radiographs

____ Other (i.e perio charting, clinical notes) please specify:

_____

I certify that this request has been made voluntarily and that the information given is accurate and to the best of my knowledge. I understand that I can revoke this authorization at any time except to the extent that action has been taken to comply with. I hereby authorize the doctor and staff of Bella Vita Dental Hillcrest to release records or knowledge concerning my dental health.

Patient Signature:_____

Date Requested:_____

*NOTE: for a complete transfer of all records on file please allow 3-5 business days for accurate processing

Please complete and fax or email this form to: 619-810-1869 / info@bellavitahillcrest.com