SCARSDALE
DENTAL GROUP

Creating Smiles for a Lifetime

Dental Records Release Authorization

Print Patient Name ____

Print Guardian name if Patient is a minor ____

From Institution or Practice Name: ____

Email Address for Institution (if acceptable) ____

Fax Number (If required): ____

I hereby authorize the release of the Patients (   ) X-ray and (   ) dental records to:
Scarsdale Dental Group
14 Harwood Court
Suite 211   Scarsdale, NY 10583
Smiles@Scarsdaledentalgroup.com

____

Patient or Guardian Signature if Patient is a minor

Smiles@Scarsdaledentalgroup.com   Office Phone: 914-723-4707