AUTHORIZATION TO RELEASE DENTAL RECORDS

In accordance with Florida Statute 456.057 (4) and Board of Dentistry Rule 64B5-17.009, I hereby authorize Dr. _____ to release a photocopy of my dental treatment records and originals or duplicates of any current x-rays to the dental office of:

Clark F. Brown, Jr., DDS, PA
2113 Sarno Road
Melbourne, FL 32935
(321) 259-9429

Patient's Name: _____ ____ _____

Date of Birth: _____

☞ Patient Signature: _____ Date _____
(Parent or legal guardian must sign if patient is a minor.)

FOR OFFICE USE ONLY

Request sent on _____

Request received on _____

Date Sent: _____

Records and x-rays to be sent: _____

_____