# 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. Clark F. Brown, Jr. DDS, PA** to release a photocopy of my dental treatment records and duplicates of any current x-rays to the dental office listed below. I understand that in accordance with Florida Statutes, I may be charged no more than $1.00 per page and $5.00 per x-ray for duplication.

Dentist Name: _____

Address: _____

City: _____ State _____ ZIP: _____

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: _____

_____