SEVERANCE DENTAL
Family and Cosmetic Dentistry

Authorization for Release of Dental Records/X-rays

Date: _____

I hereby request the last ***5 years*** of dental records/x-rays for the following patient or patients to be released to: info@severancedental.com

Severance Dental

Address: 375 W. 4th Avenue

City: Severance State: CO Zip: 80550

(Please Print Patient name and date of birth)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

_____
Signature (Parent if for a minor child)