DONALD REID D.D.S.
DENTAL ARTISTRY

Date _____/_____/_____

Authorization for Release of Dental Records and X-rays

I _____, hereby authorize the release of records
(print patient or guardian name)

concerning _____ dental health and copies of all x-rays.
(patient name (s)

Patient's D.O.B._____

Previous Dental Provider:

Doctor's Name: _____

Street Address: _____

City, State, Zip _____

Phone: Email

Please forward to:
Donald Reid, D.D.S. Dental Artistry
10330 Donner Pass Rd STE A
Truckee, CA 96161
703-212-9622

Signed Patient or Guardian _____