AUTHORIZATION TO RELEASE DENTAL RECORDS TO TIOGA DENTAL & ORTHODONTICS

TO: OFFICE NAME: _____

ADDRESS: _____

CITY/STATE/ZIP:_____

TELEPHONE: _____

I authorize the release of my dental records: clinical notes, patient forms (including medical history), photos and x-rays relevant to dental treatment and request that they be transferred as soon as possible to:

Tioga Dental & Orthodontics
13005 SW 1st Rd, Ste. 233
Jonesville, FL 32669
352-333-1946
info@tiogadental.com

PLEASE NOTE RECORDS TYPICALLY TAKE 5 TO 7 DAYS TO PROCESS

_____ _____
Name of Patient **Parent/Guardian (if applicable)**

_____
Signature of Patient or Parent/Guardian

_____
Date