Authorization to Release Records and X-Rays

Each adult patient must sign his/her own authorization form

George C. Viertl DDS
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I _____ (print full name) authorize the office of George C. Viertl DDS to receive / release (circle one) all pertinent records, radiographs. medication sheets, and any other information pertaining to dental treatment for the following patients:

Patient Name _____ (print)
Patient Name _____ (print)
Patient Name _____ (print)
Patient Name _____ (print)

To / From Dentist: (circle one)

Name	
Phone	
Email	
Address	

Patient(s) Details:

Full Name(s)	
Date of Birth	
Phone	
Email	
Address	

_____ _____

Patient Signature (parent / guardian) Date