EASTWOOD DENTAL

Dr. Emily Hilliard and Dr. William Funk
628 Eastwood St
Bowling Green, KY 42103

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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

Patient Name_____Date of Birth_____

Address_____

City_____State_____

Zip_____

Phone Number_____

Additional Family Members to be included:

Name:_____Date of Birth_____

Name:_____Date of Birth_____

Previous Dentist or Practice Information:

Name_____

City_____State_____

Phone Number_____

I, _____ authorize the release of the following:
Please Print patient/guardian name

- Panoramic of Full Mouth X-Rays- within past 5 years
- Bitewing or Periapical X-Rays- within past 12 months
- Detailed Dental Records (probing depth chart, photographs, etc.)
- Knowledge concerning the dental health of the patient(s) listed above.

I further request that these records be transferred to Eastwood Dental at the above address.

_____

Patient/Legal Guardian Signature Date