Imperial Dental
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AUTHORIZATION TO RELEASE RECORDS

Date: _____

Dr._____ Phone #_____Fax # _____

I hereby authorize and request you to release my complete history records and X-rays to:

IMPERIAL DENTAL

David M. Gulotte, D.M.D, Maria L. Hernandez, D.D.S.
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Patient(s) Name: _____D.O.B._____

Signature: _____

Current x-rays

FMX _____

BWX _____

PANO date _____

Last Visit _____

E-mail ___ Mail ___