Dental Record Release Authorization

I, ____, **authorize:**

(Print full name)

Dentist/Office:____

Address:____

City, State, Zip:____

Phone Number:______________________ * Fax:____________________

(*required)

to release my dental record, valid radiographs and periodontal chart to:

Paga Family Dentistry, PLC

112 S. Lake Street

Boyne City, MI 49712

Phone: (231) 582-9781

Fax: (231) 437-5141

Please send information to: ***Pagadental@gmail.com***

Thank you,

x____ ______________

Patient/Guardian Signature Date

Rev 6/2023