Authorization to Release Records and X-Rays

Requesting records from

Doctor _____

Address _____

_____

_____

Authorized to release records and x-rays to:

Quakertown Family Dental Center
280 Trumbauersville Road
Quakertown, PA 18951
Ph: 215-536-1562 Fax: 215-538-9694
qtfamilydental@gmail.com

Patient information

Name _____

Address _____

_____

_____

Patient Signature _____ Date _____