Dr. M. Di Santo & Dr. N Di Santo
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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Sent from Dr. Michael Di Santo & Dr. Nancy Di Santo

To Dr. _____
_____
_____

Patient's Name:	
Additional Family Members	

Date of last complete oral exam:
Date of last recall exam:
Date of last radiographs: PAN-X FMS BW'S

We, at Dr. M Di Santo & Dr. N Di Santo's dental office, have been requested by the above patient(s) to release dental records from your office. In order to insure continuity of care, past radiographs and/or other information pertinent to their continuing care are being forwarded, at their authorized request, to your location.

I hereby authorize the release of my records as requested above

Signature: _____ Date: _____

Office Verification: _____