



Durst & Jones Family Dental
2325 Washington Road | Augusta, GA 30904
Phone 706.736.7146 | Fax 706.736.9938

AUTHORIZATION TO RELEASE RECORDS

Date _____

I, _____ hereby authorize the release of my records,
(circle one: panoramic x-ray, periapical film, bitewing x-ray, diagnostic photographs
or charts) or copies of such requests that they be transferred to:

Doctors name _____
Address _____
City _____ State _____ Zip _____
Telephone (_____) _____

Please check the following:

- ___ Patient pick up himself/herself
- ___ A relative (name: _____ and relation _____)
- ___ A friend (name: _____)
- ___ Patient was referred to specialists
(Dr. _____ Specialty _____)
- ___ Patient is moving to another State
- ___ Patient is transferring Dentist
- ___ Patient request records for other purpose, (please specify _____)

Signature

Date

Print Name

Date