Watts
Family Dental

AUTHORIZATION TO RELEASE DENTAL RECORDS

To Whom It May Concern:

I, _____, hereby authorize the release of my dental records, including all current digital images or copies of current x-rays and any other pertinent information that would be necessary for my dental care to:

Douglas Watts, DDS
4601 West 109th St. Suite 222
Leawood, KS 66211

_____
PATIENT NAME

_____
DATE OF BIRTH

_____
SIGNATURE OF PATIENT (or person legally authorized to consent of patient's behalf)

_____
DATE OF SIGNATURE