

AUTHORIZATION TO RELEASE DENTAL RECORDS TO

DAVID M. HINTON, DDS

7575 Dr. Phillips Blvd. Suite 160

Orlando, FL 32819

Email: sheryl@hintondds.com

Phone: 407-363-0365

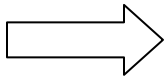
Fax: 407-363-7707

PATIENT(S) NAME(S): _____

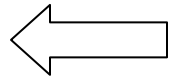
BIRTHDATE(S): _____

PHONE: _____

I AUTHORIZE THE FOLLOWING DENTIST TO RELEASE MY/OUR
DENTAL RECORDS TO DAVID M. HINTON, DDS. I AUTHORIZE THESE
RECORDS TO BE EMAILED TO THE EMAIL ADDRESS ABOVE.



PLEASE INCLUDE CHART NOTES ****AND**** ALL RADIOGRAPHS



DENTIST'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

Patient's Signature (or guardian if patient is a minor)

Date