# 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