Records Request

Authorization to Release Information

Patient:
Name:_____
DOB:_____

Additional Family Members:
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

I authorize the release of my dental records, x-rays, periodontal charting and photographs to:

Dr. McKenzie Clemens
Lowville Dental Care
5306 Parkway Drive
Lowville, NY 13367
(315) 377-2285
drclemens@lowvilledentalcare.com

Signature: _____ Date:_____

Previous Dentist:
Name:_____ Phone:_____
E-mail: _____

Please send x-rays by e-mail