



Paulette Soltis-Hamilton DMD

Family and Cosmetic Dentistry

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MEDICAL RECORDS RELEASE AUTHORIZATION FORM

I, _____ (date of birth _____), would like to request to have copies of my treatment records and any radiographs sent to the email address listed below or to my insurance company and/or other necessary parties.

To transfer x-rays (radiographs)/records **TO** our office

(from: _____), please email

X-rays/images to:

paulette@pshdental.com

OR

To transfer x-rays (radiographs)/records **FROM** our office, please email

X-rays/images to:

_____.

Patient: _____

Parent/Guardian: _____

Date: _____