Riverside Family Dentistry

609 22nd Street ◦ Moline, Illinois ◦ 61265

(309) 797-2001

Authorization for Release of Dental Records and X-rays

I hereby authorize the doctors and staff of:

Doctor Name or Practice _____

Address _____

City, State & Zip _____

to release and email records, Bitewing x-rays within the last 12 months, Full Mouth Series or Panoramic x-rays within the last 60 months, or knowledge concerning my dental health to:

Riverside Family Dentistry
609 22nd Street
Moline, IL 61265
Phone: 309-797-2001
Fax: 309-764-8236
Email: rfd609@securepracticemail.com

Patient Name: _____ Date of Birth: _____

_____

_____

Relationship to patient: _____

Signature: _____