Authorization to Release Records

Since a patient's dental records are confidential, your written authorization will allow your previous dentist to release them to another dentist or party you designate.

Today's Date: _____

Patient's Name: _____

Address: _____

_____

Previous Dentist: _____

Address: _____

_____

Phone Number: _____**Fax Number:** _____

I authorize you to transfer and or copy dental records on the following person(s)

1. _____
2. _____
3. _____
4. _____

Sign: _____

Please send x-rays in a jpg format & email to demarcowismanndentistry@gmail.com

Please mail to: Bob DeMarco, D.M.D.

Enrique Wismann, D.M.D.

8877 W Union Hills Dr., Suite 600 Peoria, AZ 85382

Office: 623-566-6478 **Fax: 623-566-7241**