Lawrence S. Singer, DDS
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Authorization for Release of Dental Records and X-Rays

I, ________________________________, do hereby give my consent and authorization to release my records or knowledge concerning my dental health to Dr. Lawrence S. Singer, DDS.

Full Dr. Name ________________________________

Website/E-Mail ________________________________

Street Address ________________________________

City, State, Zip ________________________________

Practice Telephone ________________________________

Practice Fax Number ________________________________

Copies of the following records are specifically requested:

- Progress Notes
- Letters/Reports to/from Specialists
- Periodontal Charting
- Radiographs
- Medical History Forms

Patient or Guardian Signature: ________________________________

Print Patient or Guardian name: ________________________________

Relationship to Patient: ________________

Date: ____________________________

Thank you for your time and attention to this request. Any questions please contact my office.