Prior Dentist Records Release Authorization

I, _____ authorize

Dentist: _____

Address: _____

City, State, Zip: _____

Phone number: _____

Fax: _____

Email: _____

To release copies of my dental X-rays, and a brief summary of my past treatment to:

Angela R. Schmoyer DMD
2546 Freemansburg Ave
Easton, PA 18045
Office (610)252-0646
Fax (610)252-2128
Email 1208ARS@gmail.com

Signature_____ Date_____

Additional family members: _____

_____

_____

_____

Thank You.