

Cosimi Dental Implants and Periodontics
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Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby
authorize the doctors and staff of *Cosimi Dental Implants and Periodontics* to release records or
knowledge concerning my dental health to:

Name _____

Street Address _____

City, Zip Code _____

Telephone number: _____ Fax #: _____

Email: _____

I specifically request that you release copies of:

x-rays treatment notes

Signature (patient or guardian name) _____

Printed name (patient or guardian name) _____