RECORDS RELEASE AUTHORIZATION

PARK WEST DENTAL CARE
2685 Channing Way
Idaho Falls, ID 83404

I hereby authorize and request that you release the X-rays in your possession concerning my dental treatment within your office to:

Doctor:_____
At:_____
Address:_____
_____

Patient's Printed Name:_____
Birth Date:_____
Address:_____

Patient's Signature:_____
Requested By:_____
Today's Date:_____