Authorization for Release of Dental X-rays and Records

Patient's Name: ____

Date of Birth: ____

Requesting Info from:

Doctor/Office Name: ____

Address: ____

Email address: ____

Phone Number: _________________________________Fax Number: ________________________

Please release all records, including but not limited to, Progress Notes, Operative Notes, Laboratory Test Results, Diagnostic Tests and X-rays. Records should be emailed to info@bridgemandental.org

I agree that the dental practice may communicate electronically at the email address above.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

Patient's Signature____Date: ____________________

Print Name: ____

Dr. Robert Bridgeman and Dr. Craig Bridgeman

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