Records Release Authorization

Please fill out the following information if you would like our assistance in obtaining any dental records and/or radiographs from another dental/medical provider.

Doctor's Name: _____

Address: _____

Phone: _____

I hereby authorize the release of my dental records and x-rays and request that they be transferred to:

Dr. Damian Dachowski
D3 Dentistry
3660 Bessemer Road, Suite 202
Mt Pleasant, SC 29466
Phone: 843.936.2172 Fax: 843.388.7107
smile@d3dentistry.com

Print Full Name: _____

Date of Birth: _____

Signature (Patient or Parent/Legal Guardian): _____

Date: _____