



**AUTHORIZATION FOR TIOGA DENTAL & ORTHODONTICS
TO RELEASE DENTAL RECORDS**

PLEASE NOTE RECORDS TYPICALLY TAKE 5 TO 7 DAYS TO PROCESS

I authorize Tioga Dental & Orthodontics to release my dental records, including clinical notes, patient forms (including medical history), photos and x-rays relevant to dental treatment and request that they be transferred as soon as possible to:

OFFICE NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

EMAIL ADDRESS: _____

Name of Patient

Parent/Guardian (if applicable)

Date of Birth

Signature of Patient or Parent/Guardian

Date