Patrick L. Dobash, D.D.S., P.C.
13943 N. 91st Ave., Suite H-102
Peoria, AZ 85381-3689
623-974-0500
Fax: 623-974-2212

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

I hereby authorize the doctor and staff of:

Dr./Practice Name _____
Street Address _____
City, State, Zip _____
Phone No.: _____
Fax No.: _____

to release records (including x-rays) concerning the dental health of

_____ to:

Patrick L. Dobash, D.D.S., P.C.
13943 N. 91st Ave., Suite H-102
Peoria, AZ 85381-3689
623-974-0500
Fax: 623-974-2212
officemail@drpatdobash.com

Signed: _____
(patient or guardian name)

Printed name: _____
(patient or guardian name)

Date: _____