FAMILY DENTISTRY
OF CALEDONIA

Authorization for Release of Dental Information

I, _____ hereby authorize _____
to release any and all dental records and radiographs relative to my care to:

Family Dentistry of Caledonia
9021 N. Rodgers Ct
Caledonia, MI 49316
fcaledonia@att.net

Reason for request:_____

Additional family members for whom you are requesting release of information

1. _____
2. _____
3. _____
4. _____
5. _____

Email address: _____ Telephone: _____

Signature: _____ Date: _____

Witness Signature: _____ Date: _____