

# AUTHORIZATION TO RELEASE DENTAL RECORDS



In accordance with Florida Statute 456.057 (4) and Board of Dentistry Rule 64B5-17.009, I hereby authorize Dr. McHenry to release a photocopy of my dental treatment records and originals or duplicates of any current x-rays to the dental office of:

T. Michael McHenry, DDS, PA  
214 East Eau Gallie Blvd  
Indian Harbour Beach, Fl 32937  
(321) 77 SMILE -777-6453

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Parent or legal guardian must sign if patient is a minor.)

## FOR OFFICE USE ONLY

Request sent on \_\_\_\_\_

Request received on \_\_\_\_\_

Date Sent: \_\_\_\_/\_\_\_\_/\_\_\_\_

Records and x-rays to be sent: \_\_\_\_\_

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