590 S Main Street, Wildwood, FL 34785
P: (352) 748-1880   F: (352) 748-3345
www.WildwoodSmiles.com
Email: WildwoodSmiles@gmail.com

Authorization to Release Dental Records and/or Radiographs

Date:	
Patient name:	
Date of birth:	
Telephone No.:	

I authorize Wildwood Dental Care to request a copy of my dental records and/or Radiographs from:

Practice Name:	
Phone:	
Fax:	
E-Mail:	
Mailing address:	

___________________________   ___________________________
Signature   Date

Please email digital x-rays, periodontal charting and all pertinent information to:

WildwoodSmiles@gmail.com

____
Staff

Notes:

FMX/Pano: ________________________   BWX: ________________________

Perio Chart: _______________________   HYG: _______________________