Authorization to release
Dental Records

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

_____

_____

_____

_____

_____

Email:

Patients 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:

_____