

# PEAK•VIEW

D E N T A L

Peak View Dental  
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## AUTHORIZATION FOR RECORD RELEASE

Date: \_\_\_\_\_

Patient(s): \_\_\_\_\_

Items Requested:

- ✓ Treatment History
- ✓ FMX (Last Date: \_\_\_\_\_)
- ✓ BWX (Last Date: \_\_\_\_\_)
- ✓ Periodontal Charting
- ✓ Pano (Last Date: \_\_\_\_\_)
- ✓ PA's (Last Date: \_\_\_\_\_)

Last prophylaxis & exam \_\_\_\_\_

Last seen in your office \_\_\_\_\_

Authorization: I authorize the release of records to another dental office.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
printed name

\_\_\_\_\_  
Previous Dentist Name and Phone Number