

Dr Jeffrey Baumrind Dental Record Release Form

Patient's Name _____
Social Security Number _____
Date Of Birth _____
Providers Name _____

I Hereby authorize that my dental records be released to:

Dr. _____
Address _____
Telephone # _____

Portion of record to be released

Entire Dental Record _____
X -Rays _____
Other _____ Describe _____

Signature of patient or guardian

Date

Fax # 404-659-7616

Email dr.baumrind@dr.baumrind.com