MONOKIAN
Family & Cosmetic Dentistry
Redefining The Dental Experience

Authorization to Release Dental Records

Patient's Name _____

Date of Birth _____

Address _____

I request and authorize _____ to release current radiographs for the person named above to:

Monokian Family & Cosmetic Dentistry
Treatment Coordinator
300 N. Haddon Ave.
Haddonfield, NJ 08033
856.429.0404
haddonfield@monokiandentistry.com

(provider: please send the most recent bitewings (if taken within the past 12 months) and panoramic xrays (if taken within the past 5 years). Be sure to include dates the xrays were taken.

_____ _____
Client Signature Date