MONOKIAN
family & cosmetic dentistry

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AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's Name: _____ Date of Birth: _____

Street Address: _____

I request and authorize: _____
(Provider name)

_____
(Provider address)

to release dental information for the patient named above to:

Monokian Family & Cosmetic Dentistry
151 Greentree Road , Suite A.
Marlton, NJ 08053
856.983.7714 (fax)
info@monokiandentistry.com (secure email)

This request and authorization applies to:

- ☐ Dental Records
- ☐ Treatment History
- ☒ Current Radiographs
- ☐ Perio Charting

_____
Name of Patient or Guardian (please print)

_____ Date: _____
Signature of Patient or Guardian