Records Release/Request Authorization Form

Date:____________

I hereby authorize the office of Dr. Dana Weinreich, DDS to:

Release ☐
Obtain ☐

Copies of my dental records, including current x-rays (Full-mouth series within the last 5 years and or bitewings within the last 12 months.

My records can be emailed to: office@drdanaweinreich.com

Or

Release my records to:

Facility Name:________________________

Phone:______________________________

Email:_______________________________

Print Patient Name:____

Patient/ Guardian Signature:__________________________________

Patient Date of Birth: _______________________________________

Dr. Dana Weinreich, DDS

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