PINNACLE
DENTAL GROUP

Record Release Form

Date:_____

Patient (s) Name:_____

Date of Birth:_____

Reason for release:_____

I hereby authorize Pinnacle Dental Group to release records/radiographs to:

_____
_____
_____

_____ _____

Signature Date

FAX # 779-252-1070
Email info@pinnacledentalgroup.com