CornerstoneDENTAL
Dr. Anil Ralhan Family & Aesthetic Dentistry

AUTHORIZATION FORM
Release of Dental Records

Office: ______________________________

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Date: ______________________________

Patient's Name: ______________________________

Date of Birth: ______________________________

I authorize the release of any x-rays taken by your office, the duplications of any x-rays received, and answers to any questions our new office has in regards to my previous treatment history.

In doing so, I hereby release your office from all legal responsibility or liability that may arise from this authorization.

Signature of Patient/Guardian: ______________________________

Dr. Anil Ralhan, D.D.S.

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