RELEASE OF DENTAL INFORMATION

I, _____hereby authorize
(Patient's Name)

_____ to release my complete set of
(Provider)

dental/orthodontic records to Cherubini Orthodontics. Dental information may include past dental history, treatment, radiographs, and any other pertinent information. Please send to:

Cherubini Orthodontics
17550 US Highway 17 North
Hampstead, NC 28443
910-270-0123
Fax 910-270-0129

Signature: _____Date:_____

(If a minor, parent or guardian must sign here)