Cedarburg Family DENTISTRY

New Patient(s)
Record/X-Ray Release Form

Patient Name: _____

Address: _____

City, State & Zip: _____

Additional family members:

_____

_____

I hereby authorize: _____

_____

_____

( ) -

to release my dental records and current x-rays to:

Cedarburg Family Dentistry
W64 N728 Washington Avenue
Cedarburg, Wisconsin 53012
262-377-9490

I understand that my actual dental records, by law, belong to the dentist. I understand that copies or duplicates, of such records and x-rays, will be sent.

Signature: _____ **Date:** _____