651 N U.S. HWY 183, Ste 150
Leander TX 78641
Ph: (512)260-0123
Fax: (512)260-0110

AUTHORIZATION FOR RELEASE/ REQUEST DENTAL RECORDS

I herby authorize Dr. Robert Hogge/Leander Smiles to release a photocopy of my dental treatment records and originals or duplicates of any current x-rays.

Copies of the following records are specifically requested:

- ☐ Patient Dental chart
- ☐ Periodontal Charting
- ☐ Radiographs

Please send records to: Email:_____
Office name(if applicable):_____

Patient's Name: _____

Date of Birth: _____

Patient Signature: _____ Date: _____
(Parent or legal guardian if patient is minor)

FOR OFFICE USE ONLY

Request received by _____

Request sent on _____

Request received on _____

Date Sent: _____

Records and x-rays to be sent: _____

_____