**Authorization for Release of Dental Records and X-rays**

I, (print patient or guardian name) ,

hereby authorize the doctor and staff of Dr. Rodney P. Burtons, DDS to release records or knowledge concerning my dental health to:

Full Dr. Name: 

E-mail Address: 

Street Address: ­­­­­­­­

City, Zip Code: 

Practice Phone Number: ()  -  Fax Number: ()  - 

I specifically request that you release copies of (please check):

() All X-Rays

() All Treatment Notes

Signature (patient or guardian name): 

Printed Name (patient or guardian name): 

Please complete this form and fax to (805) 435-1809 or e-mail to [Oakssmileinfo@gmail.com](mailto:Oakssmileinfo@gmail.com). Payment is required to cover the cost of duplication and/or copying patient records.