



ROBERT L. EDWARDS, DDS & LAUREN H. SHORE, DMD
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MEDICAL / DENTAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby authorize Dr. _____

(Patient name)

to release copies of my treatment records and any radiographs to the doctor's office listed above, or to my insurance company and/or other necessary parties.

I understand that these records and x-rays will be used for treatment purposes, or for claims processing and/or benefit disbursement.

Please forward all information to the address listed above. Thank you for your prompt response.

Patient Signature

Date

Patient or Guardian Name (if Patient is a Minor)

Radiographs may be emailed to: robertedwardsdds@gmail.com