Stephen P Girdlestone DDS

PEDIATRIC DENTAL SPECIALIST

infants children teenagers

Authorization for Release of Dental Records and X-rays

FIRST	MI	LAST NAME	DATE OF BIRTH

ADDRESS	TELEPHONE

CITY	STATE	ZIP

AUTHORIZATION FOR RELEASE

I _____, _____, AUTHORIZE
(RELATIONSHIP)

THE RELEASE OF TREATMENT RECORDS AND DENTAL X-RAYS FOR

MYSELF, AND THOSE OF MY DEPENDENT CHILDREN _____
(NAME)

STEPHEN GIRDLESTONE DDS
3801 WHIPPLE AVENUE NW
CANTON OHIO 44718

_____
(NAME)

_____
(NAME)

_____
(NAME)

_____
(NAME)

TO DR. STEPHEN GIRDLESTONE, 3801 WHIPPLE AVENUE NW, CANTON OHIO 44718
TELEPHONE (330) 491-7777.

SIGNATURE	DATE