Authorization for Release of Dental Records and X-rays

I,_____, hereby authorize the doctor and staff of Dr. _____

To release records or knowledge concerning my dental health to:

Dr. Michael Schroer
2654 George Washington Memorial Highway
Hayes, VA 23072

Phone 804-642-3558

E-mail images@schroerdds.com

I specifically request that you release copies of the following:

- ☐ All X-rays
- ☐ All Treatment Notes and Perio Charting

_____ _____
Signature Date

_____
Print patient or guardian name

Submit Form