Records Release Form

Name of Patient(s):

_____ DOB:_____
_____ DOB:_____
_____ DOB: _____
_____ DOB:_____

I hereby authorize the release of the dental records below:

- ❑ **Entire Chart/In date Xrays**
- ❑ **X rays Only**
- ❑ **Panoramic X-ray Only**

Please send them to:

Hansen Dentistry
Rylan J. Hansen, D.D.S., PA
800 W. Williams St., Ste 240
Apex, NC 27502
919-363-8444 Phone
919-363-6391 Fax
Email: admin@hansendentistryapex.com

_____
Signature of Patient or Guardian

_____
Date