Riverside Family Dentistry

609 22nd Street ◦ Moline, Illinois ◦ 61265
(309) 797-2001

Authorization for Release of Dental Records and X-rays

I _____, hereby authorize the doctors and staff of:

Doctor Name _____
Address _____
City, State & Zip _____

to release records, dental x-rays or knowledge concerning my dental health to:

Riverside Family Dentistry
609 22nd Street
Moline, IL 61265
Phone: 309-797-2001
Fax: 309-764-8236
rfd609@securepracticemail.com

Signature: _____

Patient Name: _____ Date of Birth_____

Relationship to patient: _____