WOLKEN

FAMILY DENTAL

Release of Dental Records

Patient Name(s): _____

Date(s) of Birth: _____

I authorize Dr. _____, located at _____

to release copies of my dental records (including Bitewing X-Rays less than 12 months old, FMX or Panoramic X-Rays less than 36 months old) to Dr. Wolken.

Electronic records are preferred and should be sent via e-mail to:

info@wolkendental.com

Printed records may be sent by postal mail to:

8888 Ladue Road Suite 200

St. Louis, MO 63124

Phone #: (314) 727-6676 Fax #: (314) 721-0930

_____ _____

Signature of patient, parent, or legal guardian Date

8888 Ladue Rd, Suite 200 Saint Louis, Missouri 63124
tel 314 727 6676 fax 314 721 0930
email: info@wolkendental.com
www.wolkendental.com