

Family Dentistry & Dental  
Specialist Group  
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**Record Release**

To: \_\_\_\_\_

For: \_\_\_\_\_

I Hereby authorize you to release to Dr. \_\_\_\_\_  
any information including the diagnosis and records of any  
treatment or examination rendered to me.

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Witness: \_\_\_\_\_