

**Reference: Authorization to release of dental records**

I hereby authorize Dr. \_\_\_\_\_ to release a photocopy of my dental treatment records and originals or duplicate any current x-rays to the dental office of:

**LAKEVIEW FAMILY DENTAL  
Carlos R. Ruiz, DDS  
371 S. Lake Havasu Avenue  
Lake Havasu City, AZ 86403  
928.855.8333**

Patient's Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_