Release Of Records

Date: _____

I,_____
authorize all records to be copied and released to:

Brett Dameron D.D.S.
12320 N. 32nd Street, Suite 1
Phoenix, Arizona 85032

E-mail: teamxray@drdameron.com
Fax: 602-992-6104

Patient Signature:

_____

From:
Dental Office
Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
E-mail: _____