TOMKO DENTAL ASSOCIATES 7525 Tilghman St., Allentown, PA 18106

# Dental Records Release Authorization

To: _____
(your past dental office)

_____

_____

I, _____authorized the release of dental x-rays and records for:

Patient Name:_____Date of Birth:_____

Other Family Members:_____Date of Birth:_____

_____

_____

Please forward records to: Tomko Dental Associates at the above address. If the x-rays are digital they can be emailed to: info@tomkodental.com

Patient's Signature:_____

Date:_____