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## PATIENT AUTHORIZATION - REQUEST FOR RELEASE OF RECORDS

Date: \_\_\_\_\_

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

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

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

I hereby authorize you to release the specific information described below to Dr. Paul F. Botsford, DMD, PC  
\_\_\_\_\_

All films within the last 5 years

Periodontal charting

Last Hygiene appointment date: \_\_\_\_\_

What type of cleaning was done at that time? \_\_\_\_\_

Has Scaling/Root planing been completed? If so, what dates and quadrants? \_\_\_\_\_  
\_\_\_\_\_

Other \_\_\_\_\_

Email digital radiographs to: [barbara@BotsfordDental.com](mailto:barbara@BotsfordDental.com) or [reception@BotsfordDental.com](mailto:reception@BotsfordDental.com) or fax/  
mail to above address.

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if signed by personal representative of patient) \_\_\_\_\_

Date \_\_\_\_\_