

Harmony Dental Arts
1066 Clifton Avenue
Clifton, NJ 07403
www.harmonydentalart.com

Radiograph & Dental Release Request

Date _____

To: Dr. _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____ (DOB : _____)
authorize the release of all dental records and radiographs or copies of my
records to the above named dentist.

Patient or Guardian
