



Records Release Authorization to Shirer Family Dentistry, LLC

I, _____, respectfully request the release of all my records (treatment progress notes and radiographs) that you have on file to the office of Shirer Family Dentistry, LLC from the office listed below. Please forward any digital images in jpeg format by email to Shirer Family Dentistry (**frontdesk@shirerfd.com**)

Patient _____

Date of Birth _____

Address _____

Telephone _____

Records released from the office of:

Dentist _____

Address _____

Telephone _____

Thank you for releasing my records to Shirer Family Dentistry, LLC.

Signature _____

Date _____