Authorization for Release of Dental Records & Radiographs

Patient(s) Information

Name(s): _____

Address: _____

Phone: _____

I/we,_____, hereby give my/our consent to Lucas Homicz, DDS, FAGD, 1226 Shore Road Cape Elizabeth, ME 04107, to release copies of my/our dental records and radiographs to the person(s) listed below:

Dentist Name: _____

Phone number: _____

Email: _____

Mailing Address: _____

Please transfer my dental records to High Tide Dental,

PA Email: contact@hightidedental.com

Mailing Address: 1226 Shore Road Cape Elizabeth, ME

04107 Telephone: 207-767-3211

Fax: 207-767-3451

Patient Signature: _____

Patient Signature: _____