Rapisarda Family Dentistry
2005 SE 192nd Avenue, Suite 201
Camas, WA 98607
Office: (360)256-2400 Fax: (360)954-5123

Authorization for release of dental records and dental radiographs

I, (print patient name) _____, birth date _____

hereby authorize the staff at: _____
(Name of previous dentist)

_____
(Address)

_____ _____
(Phone number) (Fax number)

_____
(Email address)

to release records or knowledge concerning my dental health to:

Dr. J. Kristian Rapisarda, D.D.S., P.S
RAPISARDA FAMILY DENTISTRY
2005 SE 192nd Ave Ste 201
Camas, WA. 98607
360-256-2400
Fax: 360-954-5123

Email digital x-rays and perio charts to: **info@rapisardadental.com**

Please include: Full mouth and/or pano, most recent bitewings, SRP dates, crown, endo and filling dates.

Please forward the appropriate records and/or radiographs so they will be available for my appointment on _____. If this is not possible please contact the patient or office before the above date.

Signature _____ Date _____
(Patient or guardian signature if under 18)