DOUGLAS ANGELL DDS PC
525 E. Big Beaver Rd Suite 110 Troy, MI 48083
248-362-4330
248-362-4033 Fax

CONSENT FOR RELEASE OF DENTAL RECORDS

DATE_____

PATIENTS NAME_____ **BIRTHDATE**_____

PREVIOUS NAME IF APPLICABLE_____

I hereby authorize and request Dr. Angell to release
A copy of my current x-rays and dental treatment record.

TO New Dentist _____

Address _____

City State Zip _____

_____ _____

Patient's or Guardian Signature Date **Patient's Name Printed**