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I _____authorize the release of my dental records and X-rays to Baer Dental Designs.

Patient Name: _____ D.O.B._____

Method of Transmission:

◇I will pick them up - please allow 48-72 hours for preparation of records

◇Please mail them to:

Name _____ Phone _____
Address _____ Fax _____
_____

◇Please email them to: xrays@baerdental.com

_____ _____
signature of patient or guardian print patient's name

_____
print guardian's name if not patient

_____ _____
date contact phone #