



Authorization for Release of Dental Records and X-rays

I, _____ (print patient or guardian name), hereby authorize any dentist, medical practitioner, or hospital that has records or knowledge concerning my dental health to release all such records and information to:

JOSHUA M. SOUWEINE, D.D.S.
Calm Lake Dental
1386 Hathaway Drive, Suite B
P.O. Box 25338
Farmington, NY 14425

Your assistance in mailing these records to Dr. Souweine is greatly appreciated.

I specifically request that you release copies of:

- all x-rays including panoramics
- all treatment notes
- all diagnostic information

SIGNED (patient or guardian):

PRINTED NAME:
