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RECORDS RELEASE AUTHORIZATION & REQUEST

To: _____
Doctor / Hospital

Address: _____
Street Address, Building, Apartment # City State Zip Code

I hereby authorize release of my dental records and X-rays for the period of: _____ to _____
Month / Day / Year Month / Day / Year
 and request that they (or copies) be transferred to:

Dr. A. J. Gerathy Jr.
P.O. Box 492
325 Second Street
Monument, CO 80132

Phone: (719) 481-4949

Authorizing Patient or Guardian:

_____ _____ Date: _____
Print Patient or Guardian's Full Name Patient or Guardian's Signature Month / Day / Year