RECORDS RELEASE AUTHORIZATION

To:_____

Doctor or Hospital

Address:_____

_____

_____

I hereby authorize and request my complete dental record including x-rays to be released to:

Dr. Fatemeh Hadjian D.D.S., P.A.
74-000 Country Club Drive, Suite B1
Palm Desert, CA 92260
Phone: 760-568-6900
Fax: 760-568-6914
Email: hadjiandental@gmail.com

Name:_____

Address:_____

_____

_____

Signature:_____

Date:_____