Williamsburg Periodontics

Authorization for Release of Dental Records and X-rays

I, _____, hereby authorize the doctor and staff of Dr. _____

To release records or knowledge concerning my dental health to:

Williamsburg Periodontics
461 McLaws Circle, Suite 1
Williamsburg, VA 23185

Phone 757-221-0249 Fax 757-221-0250

E-mail images@schroerdds.com

I specifically request that you release copies of the following:

_____ All X-rays
_____ All Treatment Notes and Perio Charting

_____ _____
Signature Date

_____
Print patient or guardian name