Date: __________

I hereby authorize:

_________________________________ ____________________________________

(Your previous dentist's name) (Your previous dentist's phone number)

To release any pertinent dental records of:

_____________________________________ _____________________________

(Your Name Last, First (Maiden)) (Date of Birth)

_____________________________________ ______________________________

(Address) (Phone Number)

To:
Widen Your Smile
Ronald R. Widen, DDS
2001 N. Halsted, Suite 202
Chicago, IL 60614
(312) 266-0044
Email: xrays@widenyoursmile.com

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(Signature of Patient/Legal Guardian)