PALM VALLEY
FAMILY DENTISTRY

Request to Release Medical Records

I, _____ authorize _____to release copies of my x-rays and any other pertinent information in my file to:

Palm Valley Family Dentistry
3791 Palm Valley Road, #205
Ponte Vedra Beach, FL 32082
P: 904.834.2736 F: 904.834.2737
e: frontdesk@palmvalleyfamilydentistry.com

Patient Signature: _____

Patient Date of Birth: _____

Date: _____