



Authorization for Dental Records  
To Be Released To Friesz Family and Cosmetic Dentistry

I authorize the release of my dental and medical information to Friesz Dentistry

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

|   |                               |
|---|-------------------------------|
| Last Cleaning: _____                                    | BWX (within 24 months): _____ |
| Pano (within 5 years): _____                            | FMX (within 5 years): _____   |
| Xrays:    Digital    or    Hard copy    (Please Circle) |                               |

Name of Clinic: \_\_\_\_\_

Clinic Fax: \_\_\_\_\_

Clinic Phone: \_\_\_\_\_

Clinic Email Address: \_\_\_\_\_

\*Please email digital records to: [info@frieszfamilydentistry.com](mailto:info@frieszfamilydentistry.com)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This is valid until you, as the patient, notify us of change.*

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[www.frieszfamilydentistry.com](http://www.frieszfamilydentistry.com)