HERRICK DENTAL CARE
13010 Butler Crest Drive
St. Louis, MO 63128
(314) 842-6200

# *Authorization for Release of Dental Records and X-rays*

I, ( print patient name ) _____, hereby

authorize the doctors and staff of : _____
_____
_____
Phone: _____

to release records or knowledge concerning my dental health to:

Jason M. Herrick, DDS, LLC
13010 Butler Crest Drive
St. Louis, MO 63128
314-842-6200
E-mail: herrickdentaloffice@yahoo.com

I specifically request that you release copies of all radiographs taken in the last five years and any pertinent dental records.

Signed ( patient or guardian name ) _____

Printed name ( patient or guardian name ) _____

Date Signed: _____