CENTER FOR
Dental Sleep
Medicine

Joseph Ting, DMD
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AUTHORIZATION TO RELEASE DENTAL RECORDS

Please email to: **SPGCDSM@GMAIL.COM**

1) Copy of most recent X-Rays, including Full Mouth Series/Panoramic X-Ray
2) Copy of most recent Periodontal Charting

Previous Dentist/Office Name:_____

Address:_____

City, State, Zip:_____

Phone Number:_____

I hereby give you permission to release any, and all of my dental records.

Patient's Name: _____

Patient's Date of Birth: _____

Patient's/Guardian's Signature Date

Thank you!

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