Request for Prior Records

Authorization for the Release of Dental X-Rays

I hereby authorize the office of **Prior Provider Name ,**
Prior office address or phone number to release the dental x-rays of

Patient names to auto populate to:

Please email X-Rays to: info@lafayettedentistry.com

Dr. Ryan Miyasaki, DDS

895 Moraga Road, Suite 5

Lafayette, CA 94549

This authorization is effective immediately.

Signature Date

If not signed by the patient please indicate relationship:

___parent or guardian of minor patient

___guardian or conservator of an incompetent patient

___beneficiary or personal representative of deceased patient