Roxanne Malone, D.D.S.
Gentle Family Dental Care

Authorization for Release of Dental Records

I, (print patient name or guardian)_____, hereby authorize Dr. Roxanne Malone and staff to receive records or knowledge concerning my dental health.

Please mail or email my records to:

Dr. Roxanne Malone

1511 Highway US 1, Suite 201

Sebastian, Florida 32958

(772) 589-6667

drmalone@malonedentistry.com

Additional Family Members:

_____

_____

_____

Patient Signature:_____ Date:_____