Date: _____

To Whom It May Concern:

Please consider this authorization to release any and all dental records and x-rays to:

Traverse Dental Associates, PC
555 S. Garfield Ave
Traverse City, MI 49686
Phone: (231) 947-0210
Fax: (231) 947-6770

Or send records via Email to: Joy@traversedental.com

Thank you.

_____ _____
Printed Name DOB

_____ _____
Signature Date