



Pathways

Dental Care

AUTHORIZATION FOR RELEASE OF X-RAYS AND INFORMATION

I hereby consent to the release and or transmittal of all Clinical & chart records for

Patient Name _____

Previous office name _____

Previous offices email or phone number _____

Phone number _____

Date _____ Signature _____

Please forward and date any x-rays that have been taken in the past 3 years for the above named client and or clients.

info@pathwaysdental.com

Please include dates for all of the following:

Last Recall: _____

Last COE : _____

Last Panoramic x-ray _____

Last FMS _____

Last BW`s _____