# AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

DATE: _____

I hereby authorize: _____

_____

_____

_____

To release my records and x-rays to:

**Paul A. Mevoli, D.M.D., P.A.**
**5415 Park Street North**
**Suite A**
**St. Petersburg, FL 33709**
**727-541-5606 Office**
**727-545-9723 Fax**

PATIENT'S NAME: _____

PATIENTS SIGNATURE: _____

REASON FOR RECORDS RELEASE (OPTIONAL): _____

_____

**IF SENDING DIGITAL RADIOGRAPHS PLEASE EMAIL TO INFO@MEVOLIHANCOCKDENTAL.COM IN JPEG FORMAT. THANK YOU!**