_____
Date

_____
_____
_____
_____
Dentist's Name & Address

Dental records and X-Rays release.

I, _____, authorize the dental office of Dr. _____ to release the dental information, including photocopies of treatment records and dental x-rays to the office of:

Dr. Lance Brune
Dr. Colleen Vasquez
3309 Lakeshore Ave
Oakland, CA 94610
(510) 444-4331
3309lakeshoredental@gmail.com

Please forward the photocopies and X-Rays without delay to Lakeshore Family Dentistry.

Thanks for your cooperation.

Sincerely,

_____