

# Apollonia Dental Centers

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<b>Authorization to Release Dental Records</b>
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I, \_\_\_\_\_ hereby authorize  
Dr. \_\_\_\_\_ to release my  
dental records. These records may include x-rays, treatment notes,  
charting, medical and dental history, photographs, or other  
notations relevant to my treatment.

Please circle one option:

1. Please mail, FAX, or e-mail my records to:

Apollonia Dental Centers  
3720 Gosford Road, Suite C  
Bakersfield, CA 93309  
FAX (661) 836-1242  
E-mail: [apolloniagroup@aol.com](mailto:apolloniagroup@aol.com)

2. Please release my records to this person authorized by me:

\_\_\_\_\_

3. I wish to personally pick up my records today.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date