ADVANCED DENTAL SYSTEMS
David L. Schade, D.D.S. and Associates
3913 Medical Parkway, Suite 100
Austin, TX 78756
Phone (512)458-3237 * Fax (512)458-3239

REQUEST FOR RELEASE OF PATIENT RECORDS

Patient's Name (print): _____

I authorize the release of dental records, or copies of such, and request that they be transferred to the office of:

David Schade, D.D.S.
3913 Medical Parkway, Suite 100
Austin, TX 78756

e-mail address: davidschadedds@gmail.com

Any patient information related to dental treatment, including x-rays may be released, except where limited by restrictions (below). This authorization is subject to my written cancellation at any time.

REQUESTED INFORMATION:

- x-rays taken within the past 12 months
- a complete series of x-rays taken in the past 3 years

RESTRICTIONS (limit date range, type of information):_____

_____

_____

_____ _____
signature date