

Authorization Release Dental Records/Radiographs

I, the undersigned, authorize you to	elease a copy o	of my dental	records and/or
Radiographs and mail/e-mail to:	-9		

F.H. (Rick) Waggener, D.D.S. 115 Parnell Street Merritt Island, FL 32953

(E-mail is preferred)			E-mail:	E-mail: records.dr.fhw@gmail.com				
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		*			(5.77.0)	`*		
Patient Name			Sign	nature			Date	_