Dr. Angie Gribble Hedlund, DMD, MAGD
2650 Holcomb Bridge Road, Suite 210
Alpharetta, Georgia 30022
678-352-1333
www.estheticdentalsolutions.com

Authorization for Release of Dental Records and X-rays

I, ____, hereby
authorize the doctors and staff of Esthetic Dental Solutions to release records or knowledge concerning my dental health to:

Name of Dentist: ____
Dental Office: ____
Email address: ____
Phone Number: ____

Please sign and email to: info@estheticdentalsolutions.com.

Signed (patient or guardian name) _______________________________ Date: _____________

Printed name (patient or guardian name)___________________________