I, _____, do hereby authorize Dr. _____ ,

_____(Address)_____(FAX)

_____(Phone)_____(E-Mail Address)

to release copies of all my dental records, including dental ledger for treatment history, and x-rays (JPG format) to:

Dr. Bruce L. Nelson
1776 E. Glendale Ave
Phoenix, AZ 85020
Phone # 602-678-4500
Fax# 602-331-3552
Email: info@bnelsondds.com

_____ _____

Patient Signature Date