

**RELEASE OF RECORDS AUTHORIZATION**  
**| DOB:**

Please select which scenario applies to you	
What is your previous dentist's name/practice name?	
What is your previous dentist's address?	
What is your previous dentist's phone number?	
What is your previous dentist's email address?	
What is your new dentist's name/practice name?	
What is your new dentist's address?	
What is your new dentist's phone number?	
What is your new dentist's email address?	
Please send a copy of:	
Please send a copy of:	

**RELEASE OF RECORDS AUTHORIZATION**

By signing below, I consent for my dental treatment records and/or x-rays to be transferred by email to [frontdesk@sampaiodental.com](mailto:frontdesk@sampaiodental.com).

Practice Name: Sampaio Dental  
Practice Address: 1527 Southeast 16th Place, Cape Coral, FL 33990  
Practice Phone number: (239) 772-5005

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Sampaio Dental**

1527 Southeast 16th Place, Cape Coral, FL 33990

(239) 772-5005

dentistcapecoral.com/

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Patient's signature:

Date: