

My East Cobb Dentist, PC
4200 Providence Road.
Marietta, GA 30062
voice: 770-579-6400 fax: 770-579-6100
www.myeastcobbdentist.com

Authorization for Release of Dental Records and X-rays

Patient Name: _____ DOB: _____

I hereby authorize

Dr. _____ Address _____
Phone # _____ to release my dental treatment records and
originals or duplicates of any current x-rays to the dental office of:

Erik Klein, DDS
4200 Providence Rd.
Marietta, GA 30062

OR

E-mail to: doctorklein@yahoo.com

Signed (patient or guardian) _____ Date _____

