ROBERT L. MALECKI, D.D.S., P.C.
IAN M. BEVER, D.D.S

CONSENT TO RELEASE RECORDS

I, _____, give my consent to

Dr. _____ to release my records to:

Robert L. Malecki, D.D.S., P.C.

Ian M. Bever, D.D.S.

512 S. Trumbull St.

Bay City, MI 48708

(989) 892-7663

(989) 892-8850 Fax

rmaleckidds@chartermi.net

I authorize medical, dental, radiographic, laboratory and any other information to be released as indicated above. I request my previous dental care provider to please forward all current radiographs including full mouth /panorex radiographs taken within the last five years and bitewing or single periapical radiographs taken within the last twelve months.

_____ _____

Patient or Patient's Legal Guardian Date