Fox Valley Dental Care
Dokhanchi Dental Services
243 East Indian Trail
Aurora IL 60505

I hereby authorize Fox Valley Dental Care to release my records that can include radiographs, chart entries, medical history, insurance information, and account balance to:

(Print where you want us to send your information)

Name: ______________________________

Address: ____________________________

____________________________

Phone: ______________________________

Fax: ________________________________

A photocopy of this authorization shall be as valid as the original.

(Your own informatiom)

Date: _______________________________

Patient name: ________________________

Patient or legal guardian signature: ________________________________

Date of birth: _________________________

Social Security number: _________________________

Please be advised that there is a nominal fee of $15 to $25 dollars for the copying of radiographs.