Schneider Family Dentistry
22 Montgomery Village Ave
Gaithersburg, MD 20879

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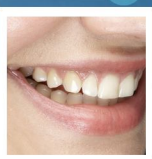
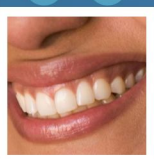
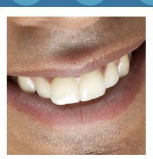

# Authorization for Request of Dental Records & X-Rays

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

**I give Schneider Family Dentistry authorization to request & receive records, concerning my dental heath (including x-rays). If records are digital, please email to: mreid@drschneiderdds.comcastbiz.net**

PREVIOUS DENTIST/PRACTICE NAME:

STREET ADDRESS OR CITY & ZIP CODE OF PREVIOUS DENTIST

* ☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

Response Date: _____