

**Authorization for Release of Dental Records and X-Rays**

I authorize the release of dental records and request they be sent to:

Sun Mountain Dental Care

Todd S Christensen, DDS

Email: smiles@sunmountaindental.com

Phone: 907-357-5757

Fax: 907-357-5758

Please include: Dental X-Rays  
Dental History  
Treatment/Progress Notes

Name of Patient(s): \_\_\_\_\_ DOB: \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Address of Previous Dentist:

\_\_\_\_\_