



**MONOKIAN**  
*family & cosmetic dentistry*

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**AUTHORIZATION TO RELEASE DENTAL RECORDS**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

I request and authorize: \_\_\_\_\_  
(Provider name)

\_\_\_\_\_  
(Provider address)

to release dental information for the patient named above to:

**Monokian Family & Cosmetic Dentistry**  
**151 Greentree Road , Suite A.**  
**Marlton, NJ 08053**  
**856.983.7714 (fax)**  
**info@monokiandentistry.com (secure email )**

This request and authorization applies to:

- Dental Records
- Treatment History
- Current Radiographs
- Perio Charting

\_\_\_\_\_  
Name of Patient or Guardian (please print)

\_\_\_\_\_  
Signature of Patient or Guardian

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