



*Dr. Angie Gribble Hedlund, DMD, MAGD*  
*2650 Holcomb Bridge Road, Suite 210*  
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*678-352-1333*  
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### ***Authorization for Release of Dental Records and X-rays***

I, \_\_\_\_\_, hereby  
authorize the doctors and staff of : \_\_\_\_\_ to release  
records or knowledge concerning my dental health to:

*Dr. Angie Gribble Hedlund, DMD, MAGD*  
*2650 Holcomb Bridge Road, Suite 210*  
*Alpharetta, Georgia 30022*  
*678-352-1333*

I specifically request that you email copies of all x-ray, intra-oral images and treatment notes,  
COE form, TMJ form, Oral DNA reports and models.  
Please email to: [info@estheticdentalsolutions.com](mailto:info@estheticdentalsolutions.com) .

Signed (patient or guardian name) \_\_\_\_\_

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

Printed name (patient or guardian name) \_\_\_\_\_