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

# *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 .

Signed (patient or guardian name) _____ Date:_____

Printed name (patient or guardian name)_____