DAVID Schimmel DMD, MAGD

Your smile is our passion.

I, _____

_____ Hereby request and give my permission to have the copies of my recent X-rays and dental records sent or emailed to Dr. Schimmel at the address below.

Such records may include medical care and treatment, illness or injury, dental history, medical history, prescruptions, x-rays, and copies of all dental records. A photocopy of this release will be as effective and valid as the original.

Signed _____ Date _____

Signed _____ Date _____

(Parent, legal guardian or patient if under 18)

email: smilesbyschimmel@verizon.net

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