I hereby authorize ____to release the dental records of the patients listed below to Mike Beckham, DDS.

Patient Name:_____________________________________ Date of Birth____________________

Records Requested: ____X-rays ___Perio Chart ___

Signature (parent if minor):_______________________________ Date ______________

Patient Name:_____________________________________ Date of Birth____________________

Records Requested: ____X-rays ___Perio Chart ___

Signature (parent if minor):_______________________________ Date ______________

Patient Name:_____________________________________ Date of Birth____________________

Records Requested: ____X-rays ___Perio Chart ___

Signature (parent if minor):_______________________________ Date ______________

Patient Name:_____________________________________ Date of Birth____________________

Records Requested: ____X-rays ___Perio Chart ___

Signature (parent if minor):_______________________________ Date ______________

Patient Name:_____________________________________ Date of Birth____________________

Records Requested: ____X-rays ___Perio Chart ___

Signature (parent if minor):_______________________________ Date ______________

Please send records to:

Mike Beckham, D.D.S.
4815 E Carefree Hwy, Suite 102
Cave Creek, AZ 85331

Digital Records may be emailed to: info@beckhamdental.com