Easton Dental Studio
Dr. Michael Hoglund, DDS
2 Martin Ct. #2 Easton, MD 21601
T (410) 822 6177 F (410) 822 0056
eastondentalstudio@gmail.com

Dental Information Release Form

Dentist ______________________________

Address ______________________________

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Phone Number _______________________

E-mail Address__________________________

I _________________________hereby authorize ________________________to discuss treatment and release any/all dental records and x-rays to:

Easton Dental Studio
Dr. Michael Hoglund, DDS
2 Martin Ct. #2 Easton, MD 21601
Telephone (410)-822-6177
Fax (410)-822-0056

Patient Name ____________________________ Date of Birth ____/____/_______

Patient Signature ________________________________