

Atlanta Dental Group PC
1634 Piedmont Avenue, NE
Atlanta, Georgia 30324
Voice (404) 874-7428 Fax (404) 873-2231
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Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby authorize any dentist, medical practitioner or hospital that has records or knowledge concerning my dental health to release all such records and information to:

Mark Allan Padolsky DDS MAGD FAOS FACMS
c/o Atlanta Dental Group PC
1624 Piedmont Avenue, NE
Atlanta, Georgia 30324

Your assistance in mailing these records to Dr. Padolsky is greatly appreciated.

I specifically request that you release copies of:

“ all x-rays including panoramics “ all treatment notes “ all diagnostic information

Signed (patient or guardian name) _____

Printed name _____