Fox Valley Dental Care
Dokhanchi Dental Services
2424 W Indian Trail, Suite E
Aurora, IL 60506
630-896-1086

I hereby authorize Fox Valley Dental Care to release my records that can include radiographs, chart entries, medical history, insurance information, and account balance to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

A photocopy of this authorization shall be as valid as the original.

Date: _____

Patient name: _____

Patient or legal guardian signature: _____

Date of birth: _____

Please be advised that there is a nominal fee of $15 to $25 dollars for the copying of radiographs.