Gregory S. Brya, DDS, PLLC

drbrya.com

4780 Okemos Road | Suite #1 • Okemos, MI 48864

drbrya@drbrya.com

(517)381-8181

Record Release / Access Form: To Our Office

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth: * _____

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth: _____

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth: _____

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth: _____

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth: _____

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth: _____

Records to Release/Access: *

◯ FMX or Bitewing ◯ Treatment Information

I authorize the release of dental radiographs and treatment records to:

Gregory S. Brya, DDS, PLLC
4780 Okemos Road, #1
Okemos, MI 48864
Please email to: drbrya@drbrya.com

Thank you for your prompt attention.

Patient Information:

Name: *

_____

_____

Signature of patient, parent or guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient: *

☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ Other

Date: * _____

Response Date: _____