

BEACHSIDE FAMILY DENTAL CARE

- I hereby authorize the release of my dental records or copies of such request that they are transferred to:

EMAIL: BeachsideFamilyDC@mydentalmail.com

ADDRESS:

Beachside Family Dental Care
755 County Road 210 W
St. Johns, FL 32259

Patient Name: _____

Patient's Signature: _____

Records Requested: _____