

Red Hills Dental Associates, PLLC

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**Email: [tina@weaverdds.comcastbiz.net](mailto:tina@weaverdds.comcastbiz.net)**

Date: \_\_\_\_\_

To Whom It May Concern:

I \_\_\_\_\_, hereby authorize the release of my dental records and /or x-rays to be transferred to: (Digital x-rays can be emailed to the address listed in .jpg form)

Dental Office: Red Hills Dental Associates

Address: 1957 Raymond Diehl Rd; Tallahassee, FL 32308

Email: [tina@weaverdds.comcastbiz.net](mailto:tina@weaverdds.comcastbiz.net)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Last 4 SS: \_\_\_\_\_

Thank you

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date