DREEM DENTISTRY

REEM HAJ-ALI, DDS, MS

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS & X-RAYS

I, (print name or guardian name) _____, hereby authorize the release of dental records or knowledge concerning my dental health to:

Name of Dental Practice: __Dreem Dentistry, LLC___

Address: 4839 W 135th St.

City, State, Zip: _____Leawood, KS 66224_____

Dental Practice E-mail: ___info@dreemdentistry.com____

I am requesting that you release the following (check 1 or both):

1. ✓ All x-rays 2. ✓ All treatment notes

Patient Name (print name): _____ DOB: _____

Patient Signature (Guardian): _____ Date: _____