



1008 West Pleasant Street
Pleasantville, Iowa 50225
Phone: (515) 848-3691
Fax: (515) 848-3692
www.stoneridgedental.org

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____; authorize you to release all current dental records including radiographs to:

*Stone Ridge Dental, PLC
1008 West Pleasant Street
Pleasantville, IA 50225*

Patient's Address: _____

Patient's Signature: _____ Date: _____
(Under 18 – parent or legal guardian signature required)

Practice name, address & contact information we are requesting records from:

*Digital x-rays can be emailed to info@stoneridgedental.org