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FAMILY AND COSMETIC DENTISTRY
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I, _____,
Patient, Parent, Guardian

authorize and release my records to the office of Dr. Christine D. Laster DDS from the following facility of: (Please list doctor's name, address, phone number and email address)

Dentist Name- _____
Address- _____
City- _____ **State-** _____ **Zip** _____
Telephone- _____ **Email Address-** _____

Please transfer all radiographs on file (with dates) as well as chart notes, periodontal charting and pending treatment plans for the following family members-

_____
_____
_____
_____

Signed- _____ **Date-** _____