Vani M. Patibandla, DDS
Records Release / Request

To: _____
(dentist)

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my dental record and x-rays for myself and those of my dependent children to:

Patibandla Dental
Vani M. Patibandla
3507 Cleveland Ave NW
Canton, OH 44709

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Signature: _____ Date: _____

Canton, OH 44709 patibandladental.com Phone 330.452.0695 Fax 330.454.5998