



HAPPY VALLEY

DENTISTRY

I, _____
hereby request and give my permission to have the copies of my recent X-Rays
and Dental records sent or emailed to Happy Valley Dentistry at the address below.

Such records may include medical care and treatment, illness or injury, dental
history, medical history, prescriptions, x-rays, and copies of all Dental records. A
photocopy of this release will be as effective and valid as the original.

Signed _____ **Date** _____

Signed _____ **Date** _____

(parent or legal guardian of patient if under 18)

Email: frontdesk@happyvalleydentistrypa.com

Happy Valley Dentistry
2013 Sandy Drive, Suite 100
State College, PA 16803

Phone: (814) 234-8527 **Fax:** (814) 234-1568