



R. BROOKS LEGG, JR., D.D.S.

LYDIA R. LEGG, D.D.S.

## RELEASE OF RECORDS

I hereby authorize and request Legg Dental Group to release all records and radiographs rendered to my family or me during our time as patients of the above office.

All records and radiographs are to be released to :

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Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date Released: \_\_\_\_\_