REQUEST FOR RELEASE OF DENTAL RECORDS

Date_____

I hereby request that my dental records and radiographs be released to:

_____
Dental Office/Dentist

_____
Address

_____
City State ZIP

_____
Patient's Name (print) Birth Date

_____
Address

_____
City State ZIP

S.S._____

Patient's Name_____
OR
Legal Guardian _____
Name (print)
Signature_____

Date_____