Request for Release of Detal Records

Patient Name:_____ Date of Birth_____
Address:_____
Telephone Number:_____

This will authorize: (Provider)
_____
_____
_____

To release to: (Provider)
_____
_____
_____

The following information:

___ Complete Dental Records
___ X-rays only

_____
Signature of Patient or Guardian

Date:_____

OFFICE USE ONLY
Copied by:_____Date:_____
Sent on Date:_____