Office Name: _____

Office Address: _____

Office City/State/Zip: _____

Office Phone Number: _____

Request for Release of Records

Date: _____

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

To (Doctor or Hospital): _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____

Date of Records: _____

Patient's Signature:_____