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: Powered by TCPDF (www.tcpdf.org)