

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: \_\_\_\_\_