Records Release Form

To:_________________________
(Dentist/Dental Office)

Address:___________________________

City:____________ State:_____ Zip:_______

I hereby authorize the release of my dental records which may include the following: Progress Notes, Periodontal Charting, Radiographs,and Treatment Plans; and request that all materials be mailed or emailed to:

Email:
Ashlynelfd@gmail.com
Amandaelfd@gmail.com

____
Print Name

____
Patient Signature Date

____
Date of Records