



A Different Kind of Dentistry
Restorative • Cosmetic • Implants • TMJ Therapy

RECORDS RELEASE

DENTIST'S NAME _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS: _____

I, _____ REQUEST THE RELEASE OF MY DENTAL RECORDS AND
RADIOGRAPHS TO THE ABOVE NAMED DENTIST.

PATIENT NAME: _____ DATE OF BIRTH _____

Print Patient Name/Parent or Guardian Date

Patient Signature/Parent or Guardian Date