DENTAL RECORDS RELEASE FORM

DR. JASON M. RAMPTON PC
16635 CENTERFIELD DR. SUITE 207
EAGLE RIVER, AK 99577
907-694-5207
907-694-5213 (FAX)

PATIENT NAME _____

DATE OF BIRTH _____

PHONE NUMBER _____

ADDITIONAL FAMILY MEMBERS AND DATES OF BIRTH

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I AUTHORIZE **DR. JASON M. RAMPTON PC** TO REQUEST MY PREVIOUS DENTAL RECORDS FROM:

_____

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I REQUEST **DR. JASON M. RAMPTON PC** TO FORWARD MY DENTAL RECORDS TO:

_____

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PATIENT SIGNATURE _____ DATE _____