



RELEASE/REQUEST FORM OF PATIENT DENTAL RECORDS

Patient's Name: _____

Patient's DOB: _____ Phone: _____

Patient's Address: _____

Signature of patient or patient's authorized representative – please indicate relationship status is signed by anyone other than patient (parent, legal guardian, etc.)

Signature: _____

Date: _____ Relationship: _____

Send forms to:

Name: _____

Address: _____

Please fax the completed form to: 360-200-4923 or email to dreamdentistrylongview@gmail.com

Allow 1 week for processing.