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REQUEST FOR RELEASE OF RECORDS

I,______________________________, hereby request and give my permission to

DR. __________________________, to provide DR. _______________________

with any and all information he/she requests with respect to the dental

treatment of the above named patient.

I agree to pay the cost of duplicating any records. A facsimile or photograph of

this release will be as effective and valid as the original.

Signed: _____________________________________
(Patient)

Signed: _____________________________________
(Parent, legal guardian or custodian of the patient, if a minor)

Date signed: ______________________

Facility Name: ____________________________________

Facility Address: _____________________________________

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Office Contact: _____________________________________