DENVER
FAMILY DENTISTRY

Date: _____

I hereby request the dental records/ radiographs for the following patient or patients to be released to/from:

Dentist or Patient:_____
Address_____
City:_____State:_____Zip:_____
Phone Number:_____Fax:_____

Please print patient name and date of birth
Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

_____ _____
Signature (Parent if for a minor child) Date