RECORD RELEASE FORM

I, _____, request the release of dental records relevant to dental treatment, or copies of such, and request that they are transferred to:

Dr. A. Andrew Wilson III, DDS

4410 N Midkiff Rd, Ste D217

Midland, TX 79705

A2WDDS@yahoo.com

Name of Patient: _____ Date of Birth:_____

Dependents:

Name of Patient:_____ Date of Birth:_____

Name of Patient:_____ Date of Birth:_____

Name of Patient: _____ Date of Birth:_____

Records being requested:

( ) Current Radiographs ( ) Treatment Records ( ) Charts

( ) Other_____

Signature of Patient/Guardian: _____Date:_____