RECORDS RELEASE REQUEST

Date _____

To _____
(DOCTOR)

Address _____

City _____ State _____ Zip Code _____

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

Abbott Family Dentistry
1601 Abbott Road, Suite 102 - Anchorage, AK 99507
(907) 336-8478 / Fax (907) 336-8873

_____

Print name of Patient Signature (patient, parent or guardian)