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
andrewwilsondds@gmail.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_____

From:
Previous dentist name:_____

Dental office phone #_____

Signature of Patient/Guardian:_____Date:_____