Records Release Request

Date:_____

TO:_____

(Doctor/Physician)

Address:_____

City:_____ State:___ Zip:_____

Phone:_____ Fax:_____

Email:_____

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

Forest Square Dental

444 Forest Square

Longview, TX 75605

_____

Print Name of Patient Date of Birth

_____

Signature (patient, parent, guardian)