Records Release Request

Patient Name: ___________________________________

Patient's Date of Birth: _________________

Address:____

City:_________________________ State:_______ Zip:______________

Additional family members to be included:

Name: ___________________________ DOB: ____________________

Name: ___________________________ DOB: ____________________

Name: ___________________________ DOB: ____________________

Name: ___________________________ DOB: ____________________

I, (printed patient or guardian name) ____________________________, hereby authorize the release of dental records or knowledge concerning the dental health of the patient(s) listed above. I further request that these records be transferred to the address listed below:

◯ **Bushnell Family & Cosmetic Dentistry**
65 CR 542W
Bushnell, FL 33513
Fax: 352-569-0213
bushnelldentistry@ident.com

◯ _______________________
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Signed (patient or guardian signature): ___________________________________

Date: __________________