REQUEST FOR RELEASE OF DENTAL RECORDS

Patient Name: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Home: _____ Cell: _____

Northern Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Home: _____ Cell: _____

I hereby request that my Dental Records be released to:

_____

Sun Smile Dentistry

Cosmetic • Implant • Root Canals • Same Day Crowns • Laser & General Dentistry

Ariosto Rosado, DMD

3440 Conway Blvd., Suite 2A
Port Charlotte, FL 33952

941-629-4311
info@sunsmiledentistry.com

Date: _____

Patient's Signature: _____