Request for Dental Records

Date: ____

To: ____

Dentist/Office Name

Address: ____

City: ______________________ **State:** ___________ **Zip:** ______________________

Phone: ____________________________________ **Fax:** ______________________

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

Open and Affordable Dental and Braces
6375 Lehman Dr. #200
Colorado Springs, CO 80918
Phone # 719-593-9182 || Fax # 719-204-4499
Email: coloradosprings.north@openandaffordable.com

____

Print name of patient **Date of Birth**

____

Signature (patient, parent, guardian)

Additional Notes: ____

____

____