Open and Affordable Dental and Braces®

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
12357 E. Cornell Ave., Suite 10
Aurora CO, 80014
Phone # 303-337-5800 || Fax # 303-632-7227
Email: aurora.south@openandaffordable.com

_____
Print name of patient **Date of Birth**

_____
Signature (patient, parent, guardian)

Additional Notes: _____

_____

_____