



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
12501 E. Lincoln Ave. #102
Englewood, CO 80112
Phone # 720-262-3607 || Fax # 720-262-3607
Email: parker.west@openandaffordable.com

Print name of patient Date of Birth

Signature (patient, parent, guardian)

Additional Notes: _____
