



## 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**  
202 North 2nd Street  
La Salle, CO 80645  
Phone # 970-284-7930 || Fax # 970-284-6635  
Email: lasalle@openandaffordable.com

\_\_\_\_\_  
Print name of patient Date of Birth

\_\_\_\_\_  
Signature (patient, parent, guardian)

Additional Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_