



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
935 N. Lincoln Ave.
Loveland, CO 80537
Phone # 970-541-2183 || Fax # 970-624-0458
Email: loveland@openandaffordable.com

Print name of patient Date of Birth

Signature (patient, parent, guardian)

Additional Notes: _____
