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
7859 6th St., Suite 150
PO Box 671
Wellington, CO 80549
Phone # 970-568-4442 || Fax # 970-818-0844
Email: wellington@openandaffordable.com

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

_____
Signature (patient, parent, guardian)

Additional Notes: _____

_____

_____