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Lakewood, CA 90713
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# Request for the Release of Records

Date _____

**Patient Name** _____ **Patient Name** _____

Date of Birth _____ Date of Birth _____

**Patient Name** _____ **Patient Name** _____

Date of Birth _____ Date of Birth _____

**Patient Name** _____ **Patient Name** _____

Date of Birth _____ Date of Birth _____

To _____

Address _____

City, ST, ZIP _____

Phone _____ FAX _____

E-Mail _____

I authorize the release of my dental records, or copies of such and request they be transferred the above named dental office:

Signature of patient or parent/guardian _____

Printed name of patient or parent/guardian_____

Phone _____