Requesting Dental Records

Patient Name: _____ Date of Birth:_____

Address: _____

Phone: _____

Relation to the patient :_ Self _ Spouse _ Child/ Guardian _ Other (please specify)

_____

To Doctor: _____

_____

_____

By signing this form, I am authorizing the release of my dental records to:

Fox Family Dental
832 N. Kingshighway
Cape Girardeau, MO 63701
(573) 334-8431
(573) 334-7631 Fax
amber@foxfamilydental.com

Signature: _____ Date:_____