



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: _____