STEVEN A. SAXE, D.M.D.
1570 S. RAINBOW BLVD.
LAS VEGAS, NV 89146
(702) 258-0085

I, ____, AM A PATIENT OF DR. S. SAXE. I HEREBY RELEASE MY RECORDS TO: (circle one) MYSELF MY DOCTOR/DENTIST. I UNDERSTAND THAT THE RECORDS THAT I AM REQUESTING ARE A PART OF MY PERMANENT RECORD HERE AT DR. S. SAXE OFFICE. I AM REQUESTING:

(circle one) MY: X-RAYS DOCTORS NOTES LABS REPORTS MY ENTIRE RECORD

____
PATIENT SIGNATURE DATE

____
GUARDIAN SIGNATURE IF A MINOR DATE

____
WITNESS DATE