WHITE HOUSE DENTAL
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Records Release Request

Patient Name: _____ _____
Last First M. Date of Birth

Forward records to
Office Name: _____
Address: _____

_____
Office phone # _____ Office Fax: _____

Forward records from
Office name: _____
Address: _____

_____
Office Phone # _____ Office Fax: _____

I hereby give my permission for release of any and all Medical and/or Dental records pertaining to me or immediate members of my family to the office listed above.

Additional Comments: _____

_____

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_____

Signature: _____ Date: _____