RIVER FOREST

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Records Release/Request

To:____

Address:______________________________________

City:________________State:_______Zip:__________

Phone:_________________Fax:__________________

Email address:___________________________________

I hereby authorize the release of my dental record or copies of such and request that they be transferred;

To:____

Address:______________________________________

City:________________State:_______Zip:__________

Phone:_(___)________________Fax:_(____)________________

Email address:___________________________________

____
Print name of patient(s)

Xrays requested: _________________________

X____
Patient/Parent/Guardian Signature Date

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