RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

_____

Patient Name:	**Date of Birth:**

Records being requested: ( ) Current radiographs ( ) Dental Health Status ( ) Reports ( ) Diagnostic Casts ( ) Treatment Record ( ) Charts ( ) Health History ( ) Photos

() Other: _____

Patient/Legal Guardian Signature: _____ Date: ____/____/____

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Please send records to:
Kennedy Dental Group
625 E 34th Ave Suite #301
Anchorage, AK 99503
Phone: 907-277-5684 Fax: 907-277-5694
Kdkennedy@kennedydentalgroupllc.com