RECORDS RELEASE AUTHORIZATION

DATE_____

TO:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE:_____FAX:_____

EMAIL:_____

I AUTHORIZE THE RELEASE OF DENTAL RECORDS RELEVANT TO DENTAL TREATMENT, OR COPIES OF SUCH, AND REQUEST THEY BE TRANSFERRED TO:

SALT RUN FAMILY DENTISTRY
MICKEY LETH, DMD
BERT TAVARY, DDS
SABRINA WALL, DDS
700 ANASTASIA BOULEVARD
ST AUGUSTINE, FL 32080
TELEPHONE: 904-824-3540
FAX: 904-824-3541
EMAIL: office@saltrundental.com

_____ _____

PATIENT DATE OF BIRTH

_____

SIGNATURE (PATIENT, PARENT, GUARDIAN)