RECORDS RELEASE REQUEST

 DATE: \_\_\_\_\_\_\_\_\_\_\_

 I authorize the release of my dental records FROM Halfmoon Family Dental.

Please forward my records to:

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_