RECORDS RELEASE REQUEST

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

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

Please forward my records to:

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

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