REQUEST FOR RELEASE OF DENTAL RECORDS

I, ___________________________________hereby request that Dr.________________________ release the following dental records to:

Donald G. Sampson, DDS

6939 Littlerock Rd SW, Suite B

Tumwater, Wa 98512

360-352-0401

Office@tumwaterfamilydentistry.com

Patient is scheduled in our office on____

Please release the following records for each person identified below prior to the above date:

___ Patient chart notes, regarding:____

___X-rays, periodontal chart and dates of last cleaning.

****If patient is a periodontal patient, please provide the most current date of SRP'S**

UR:___________ LR:__________UL:_________LL:____________

I am over the age of 18 and am requesting the release of dental records for:

___ Self (Each person of 18 must complete this form) DOB:____________

_______________________________________(a minor child) DOB:____________

Name

______________________________________(a minor child) DOB:____________

Name

________________________ ________________________ ________________________

SIGNATURE PRINT NAME DATE SIGNED