RECORDS RELEASE FORM

I, ______________________________ hereby request that Dr. ______________________________
(Name)

at ____
(Address City, State, Zip) (Phone xxx-xxx-xxxx)

release a copy of my dental records and radiographs (x-rays) , to include the most recent Panograph or Full Mouth Series and any Bitewings or Periapicals to Dr. Peter Amundson.

Please send to:

Peter B. Amundson
7960 South University Blvd., Suite 200
Centennial, CO 80122

Phone: (303) 773-9400
Fax: (303) 773-9518
Email: info@TheGreatSmile.com

Patient Name:	**Patient SS#** (xxx-xx-xxxx)
Additional Family Members:	**Family Member SS#** (xxx-xx-xxxx)
1.	
2.	
3.	
4.	
5.	
Signature:	**Date:** (xx-xx-xxxx)

This information is NOT shared with anyone outside this office. This material is strictly confidential and collected soley for the use of this office to process your medical/dental records chart. This data will be stored in your dental record. This information will not be shared with anyone without written consent that is signed and dated only by you.