REQUEST FOR RELEASE OF DENTAL RECORDS

I, _____, hereby request that

Dr. _____release the following dental records to:

John C Walker, DDS
1105 4th Avenue East Suite B
Olympia, WA 98506
360-754-5363
info@smileolympia.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