RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Rydell Family Dental

15704 W US HWY 63

Hayward, WI 54843

Rydelldentistry@cheqnet.net

(Email is preferred)

Previous Dental Office:

_____

_____

_____

Name of Patient: _____ Date of Birth: _____

Records being requested:

( ) Current radiographs ( ) Reports ( ) Charts

Signature of Parent/Guardian: _____ Date: _____