

RECORDS RELEASE REQUEST

DATE _____

DENTIST or OFFICE NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIPCODE** _____

PHONE _____ **FAX** _____

I AUTHORIZE THE RELEASE OF DENTAL RECORDS RELEVANT TO DENTAL TREATMENT, OR COPIES OF SUCH, INCLUDING XRAYS, CHART NOTES, AND PERIO AND RESTORATIVE CHARTING TO:

Abbott Family Dentistry, LLC

Robert P. Pierson, D.D.S.

1601 Abbott Road, Suite 102 ~ Anchorage, Alaska 99507

Phone (907) 336-8478 - Fax (907) 336-8873

or E-MAIL TO: ak907dentist@aol.com

NAME _____ **DOB** _____

SIGNATURE _____ **DATE** _____

(PATIENT, PARENT OR GUARDIAN)

PLEASE LIST ANY DEPENDENTS THAT YOU WOULD ALSO LIKE TO HAVE THEIR RECORDS TRANSFERRED TO OUR OFFICE:

NAME _____ **DOB** _____

NAME _____ **DOB** _____

NAME _____ **DOB** _____

NAME _____ **DOB** _____

NAME

DOB

NAME

DOB
