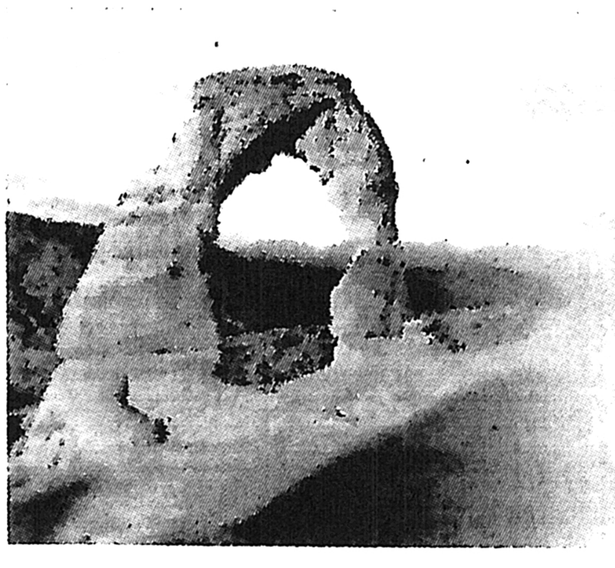

GREGORY GORMAN D.M.D.

Family & Cosmetic Dentistry

Dental Records Release Form

Patient Information

Name: _____ **Date of Birth:** _____

Authorizes: _____

To Release Records to:

Dr. Gregory J. Gorman DMD

Send To:

Address: Gregory J. Gorman, DMD LLC
1190 Bookcliff Ave, STE 201
Grand Junction, CO 81501

Phone:

E-Mail: info@Ggormandmd.com

Information To Be Disclosed:

Treatment Plan & Radiology Films/ Images

Signature of Patient/Legal Guardian:

Sign:_____**Date:**_____