Request for release of dental records

Patient/Guardian, Please complete this form and send it to your previous dentist. Thanks.

Requesting records from:

Doctor: ____

Address: ____

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Authorized to release records and x-rays to:

Dr. Ryan Koichi Frasco, D.D.S
Kapahulu Dental Center
3358 Campbell Avenue
Honolulu, HI 96815
www.kapahuludental.com
808-734-8820 / Fax 808-732-6006

For digital x-rays please email to: info@kapahuludental.com

Patient Information:

Your name: ____

Address: ____

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Patient /Guardian Signature   Date