Lakeland
DENTAL PROFESSIONALS

Request For Release of Dental Records/Xrays

Physician: _____

Address: _____

Patient Name: _____

Date of Birth: _____

Patient's address: _____

I _____, request that my Dental Records/X-rays

be released to:

Lakeland Dental Professionals PLLC

310 East Highland Drive

Lakeland, FL 33813

Patient Signature: _____

Date: _____