Loving
FAMILY DENTAL

Ph. 480.836.7600 Fax 480.836.1502

Consent for release of records from:

Dentist Name: _____
Address: _____
_____
City: _____ State: _____
Zip code: _____
Phone: _____Fax: _____

I, _____, consent to have copies of my dental records including notes, probings, and radiographs forwarded to

Loving Family Dental
16838 East Palisades Blvd.
Building A, Suite 111
Fountain Hills, AZ 85268

Or email to:
info@lovingfamilydental.com
(please send as individual dexis files if possible)

Patient name: _____
Date of Birth: _____
Address: _____
_____
City: _____ State: _____Zip code: _____

Phone: _____

Signature: _____ Date: _____