Ph. 480.836.7600 Fax 480.836.1502

Consent for release of records from:

Dentist Name: ________________________________
Address: ______________________________
____
City: ___________ State: _______
Zip code: __________
Phone: ______________Fax: ____________
Email: _______________________________

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: _________________