Patients Records Release Records

Previous Dentist:_____

Address:_____

City:_____

State:_____

Zip:_____

Patients Name:_____

Patients Birth Date:_____

I hereby authorize the release of all dental records and or xrays relevant to dental treatment to

Dr. Kelly Hollis D.D.S M.A.G.D.

2320 Dogwood Rd.

Dover, PA 17315

Phone 717-292-6548

Email: Hollisdds@hotmail.com

SIGNATURE:_____ DATE:_____