RECORDS RELEASE REQUEST

Date:_______________

To:_______________________________________
(Dental Provider's Name)

Address:____

CIty:______________________ State:___________ Zip:__________

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

2240 W. Everest Lane Suite150
Meridian, ID 83646
Office Phone # 208-608-2098

PLEASE EMAIL RECORDS TO:
info@myalliancedentalcare.com

Printed Full Name of Patient:______________________________________

Signature of Patient or Guardian:___________________________________