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:

270 S Ten Mile Rd #100 Meridian ID 83642
Office Phone # 208-608-2098

PLEASE EMAIL RECORDS TO:
info@myalliancedentalcare.com

Printed Full Name of Patient:_____

Signature of Patient or Guardian:_____