Authorization for Release of Dental Records/X-rays

Mountain West Family Dentistry
9299 S. Broadway, Suite 200
Highlands Ranch, CO 80129
303-791-6700 Office 303-791-6701 Fax
info@chatterleydentistry.com

Date: _____

I hereby request the dental records/x-rays for the following patient or patients to be released to:
Mountain West Family Dentistry

Please email all x-rays to: info@chatterleydentistry.com

Patient: _____

Address: _____

City: _____ State: _____Zip:_____

(Please Print Patient name and date of birth)

Name: _____ DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

_____

Signature (Parent if for a minor child)