RECORDS RELEASE FORM

Date: _____

Name of Office/Doctor releasing records:_____

I, _____, authorize the release of my dental and medical records pertinent to my dental treatment to:

Dr. Jeffrey G. Putney

12320 W Oklahoma Avenue

West Allis, WI 53227

414-321-6890

office@jeffputneydds.com

Patient Name and DOB: _____

Patient/Guardian Signature:_____