RECORD RELEASE FORM

To: _____
(Doctor/ Physician)

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

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

Michael V. Murphy

821 Big Tree Rd.

South Daytona, FL 32119

Telephone: 386-767-8383 Fax: 386-310-4128 Email: MMurphyfrontdesk@gmail.com

Name of Patient: _____ Date of Birth: _____

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Records being requested:

( ) Current radiographs	( ) Dental Health Status	( ) Reports
( ) Diagnostic Casts	( ) Treatment Record	( ) Charts
( ) Health History	( ) Prescription Records	( ) Photos

( ) Other:
_____

Signature of Patient/ Parent/Guardian: _____ Date: _____