RECORDS RELEASE REQUEST

TO: ____

Address: ______________________________________

Phone: ________________ Fax: ________________ E-Mail:___________________________

I authorize the release of a hard copy of my dental treatment records and digital copies of all of my x-rays, including CT scans, transferred from:

Dentistry by April Detar, LLC
2182 Sandy Dr. Suite 102
State College, PA 16803
Phone: 814-234-4444
Fax 814-954-5652
Email: info@dentistrybyaprildetar.com

Printed Name: ____________________________ Date of Birth: ______________________

Signature: ____ Date: ___________________

Please list additional family members you're requesting to be released:

Name: ____________________________________ DOB:____________________

Name: ____________________________________ DOB:____________________

Name: ____________________________________ DOB:____________________

Name: ____________________________________ DOB:____________________

Name: ____________________________________ DOB:____________________