RECORDS RELEASE/REQUEST

To _____
(Dentist/Clinic)

Address _____
City_____State_____Zip_____
Phone _____Fax_____

I hereby authorize the release of my dental records or copies of such and request that they be transferred/ forwarded to:

Dr. William Dern D.D.S.
605 Cassidy Street
Oceanside, CA 92054
Office (760) 433-6111
Fax (760) 433-4819

Print Name of Patient

Please forward current radiographs including FMX, if less than 5 years.

Patient's Signature Date