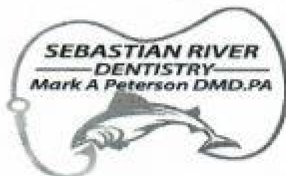

RECORD RELEASE

I, ____ request a copy of my medical and dental records, including x-rays and perio-charting , be released.
E-mail to: mptoothfixer@aol.com

X____ Date ____________________
Signature of patient, parent, or guardian

PATIENT INFORMATION

Patient's name: ________________________________ Guardian (if under 18): ____________________________

Address: ____

Date Of Birth:

REQUEST FROM

Name of Dentist:

Phone #:

Fax #:

Thank you for your corporation in this matter,

X____ Date ____________________
Mark A. Peterson, DMD, PA.