Lamb Family Dental

Dr. Bryan H. Lamb DMD

.gentle as a lamb.

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RECORD RELEASE

Date: _____

Patients Name: _____DOB: _____

Address: _____ Phone Number: _____

This form is to authorize the release of medical records including x-rays from:

Current Dentist:

Name: _____

Address: _____

Phone number: _____ Fax: _____

Please send records to:

Dentist Referred To:

Name: _____

Address: _____

Phone number: _____ Fax: _____

I consent to the release of all dental records and notes including x-rays obtained through my entire course of all dental treatment and diagnosis from any dentist who has provided me with a care at any time in the past, present or future.

Signed: _____ Date: _____