SAPPHIRE
DENTAL
PLLC

Records Release

I hereby authorize _____to release all of my personal dental records and any recent X-Rays. I also authorize you to release the additional family records member that I am authorized to sign for:

Name: _____ DOB _____

Name: _____ DOB _____

Name: _____ DOB _____

Please send records and X-rays to:

Name: Sapphire Dental PLLC

Mailing Address: 210 1st Ave East

Kalispell, MT 59901

Phone: 406-752-2180

Fax: 406-752-5276

Email: sapphirefront@gmail.com

_____

Patient's Signature Date

_____

Printed Name Date