RECORDS RELEASE REQUEST

Date_____

Dr._____

Address_____
Phone_____ Fax_____
Email_____

I authorize the release of records and x-rays relevant to dental treatment, or copies of such, and request that they be transferred to:

Walter L. Glass, D.D.S.
7325 S. Pierce St. Suite 201
Littleton, CO 80128
Phone: (303) 979-4981 Fax (303 933-6937
Email wlgdds@gmail.com

_____

Print name of patient **Date of Birth**

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Signature of Patient (or parent/guardian)