Records Release Request

Date: _____

Office Name: _____

Phone Number: _____

Fax Number: _____

I, _____ authorize the release of my dental records, including x-rays, dates of last service, and any other pertinent information regarding my dental health to:

PV Dentistry

8154 E Florentine Rd, Ste B

Prescott Valley, AZ 89314

P: (928) 772-8175

F: (928) 772-8351

Email: pvdentistry8@gmail.com

Signature: _____

Patient or parent/guardian

Print Name: _____

Dependents: _____

_____

_____