REQUEST FOR RELEASE OF RECORDS

Date _____

Dentist/Doctor_____

Address_____

_____

_____

Phone_____

Fax _____

I hereby request my complete records be release to:

Soulard Family Dentistry
2229 South 12th Street
St. Louis, MO 63104
(314) 771-3011
soularddental@att.net

Patient's Name_____

Date of Birth_____

SS#_____

Patient's Signature_____