RECORDS RELEASE REQUEST

PATIENT NAME: _____

To: _____
Doctor

Address: _____

City: _____ State: _____ Zip: _____

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

Melissa A. Morrow, D.D.S., P.C.
Pediatric Dentistry
5695 Babbitt Street – P.O. Box 70
Haslett, Michigan 48840 – (517)339-0040
morrowsdds@yahoo.com

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____