Release of Dental Records

Date:________________

To:
Provider Name: ______________________________________
Address Line 1: ______________________________________
Address Line 2: ______________________________________
Phone Number: ______________________________________
Email Address: ______________________________________

I, ________________________________, hereby authorize that you release all data pertinent to your treatment of me including and x-rays, diagnosis, and treatment to:

Woodruff Dental PLLC
Gabriel T. Woodruff DMD
6500 N. Scottsdale Rd., Ste. B-200
Scottsdale, AZ 85253
(480)946-6503 p
(480)945-8248 f
dr.woodruff.dentistry@gmail.com

(dexis or jpeg format)

Thank you.

Reason for transfer of records: (please check)
□ 2nd Opinion □ Location □ Other:________________________________

__________________________________ Patient's Name (please print)

__________________ Patient's D.O.B.

__________________________________ Patient's Address Line 1

__________________________________ Patient's Address Line 2

__________________________________ Patient or Responsible Party's Signature

________________ Date