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Request for Release of Records

Date: _____

Patient Date of Birth: _____

Patient Contact Phone Number: _____

I _____do hereby consent and

authorize _____to disclose to

Donald R. Ratliff, D.D.S. any information in my record, including current and previous dental records.

_____Radiographs

_____Treatment/Progress Notes

_____Periodontal Charting

_____Letter/Reports from Specialists

_____
Patient or Guardians Signature

_____
Patient or Guardians Printed Name

_____
Relationship to Patient

*Thank you for your assistance. Any questions please feel to call our office.