HAXTUN DENTAL CARE
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RECORDS RELEASE FORM

Dental X-rays and/or Records

____ ____________________
Patient's Name | Patient's Date of Birth

I, ______________________________________ do hereby give permission to Haxtun Dental
Responsible Party-Please Print

Care and Dr. Whitney to copy dental x-rays and/or records of noted patient and send them to the provider of my choice, as listed:

____
Provider's Name

____
Provider's Address, City, State, Zip Code

____
Provider's Email Address

____
Provider's Phone Number

SEND: **X-RAYS:** _______ **NOTED RECORDS:** _______

CHECK ONE: **PLEASE MAIL (USPS):** _______ **PLEASE EMAIL:** _______

____
Responsible Party Printed Name

____
Responsible Party Signature

____
Date