RECORDS RELEASE REQUEST

Date:

Doctor:

Address:

Phone number:

Fax number:

I authorize the release of dental records/all x-rays relevant to dental treatment, or copies of such, and request that they be transferred to:

Kevin A. Rauter, D.D.S., P.C.
16921 E. Palisades Blvd., Ste. 111
Fountain Hills, AZ 85268
Phone (480)816-1011
Fax: (480)816-8063

E MAIL: krauter1111@gmail.com

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Name of Patient or Guardian (Print) Signature of Patient or Guardian