Abilene Dental
5309 Buffalo Gap Road - Abilene TX 79606 - 325-692-3344

Request for Release of Records

Date: ______________________

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

To (Doctor or Hospital): ____

Address: ____

City: _______________________________ State: __________ Zip: ____________

Patient Name: ____

Date of Records: ____

Patient's Signature:____