RELEASE OF RECORDS

TO: Dr.

Fax Number:
Address:

Please release the following from my records, for the purpose of continuing care:

[ ] Radiographs

[ ] Examination records

[ ] Treatment Notes

and send them to:

Boulder Holistic Dentistry
2006 Broadway Suite 201
Boulder, CO 80302

For electronic transfer of radiographs and records, please send to:

images@BoulderHolisticDentistry.com

Please advise patient of any charge for duplication.

Thank you,

Patient's Name: _____

Patient's Signature: _____ Date: _____