Boulder Holistic Dentistry

Records Release Authorization

I, _____, hereby authorize the release of my records, or knowledge concerning my dental health.

To/From: Practice Name: Boulder Holistic Dentistry

Doctor Name: Dr. Andrea Mustian, DMD

Street Address: 3450 Penrose Place Suite 120

Boulder, CO 80301

Email: images@boulderholisticdentistry.com

From/To: Practice Name: _____

Doctor Name:_____

Practice Name:_____

Practice Phone: _____

Email:_____

Patient Signature:_____ Date: _____

Printed Name: _____

Please email all X-Rays, Perio Charting and Treatment information within one year