Records Release Request

I authorize release of my dental records, including x-rays relating to dental treatment to Arbor Creek Dental office;

Requesting records from the office listed below :

Name of Office_____

Address_____

_____

Phone# **Fax#** **Email:**

Patient Name:

_____

_____

_____

_____ _____

Patient Name/ Responsible Party: **Date**

From:
DR. JASON KNAG DDS
ARBOR CREEK DENTAL
15990 S Bradley Dr. #102
Olathe, KS 66062
913-390-5300 /FAX 913-390-5310
info@arborcreekdental.com