Records Release Request

To: ___________________________________

Address: _____________________________

City: ____________ State: ____ Zip: _______

Phone: _____________ Fax: _____________

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

info@jennifergrantdds.com

Jennifer Grant, D.D.S.

1601 Lake Success

Waco, Texas 76710

254/235/4986

Name of Patient: ______________________________

Date of Birth: ________________________________

Signature: ___________________________________

Date of Request: ______________________________

Records Release Request

I hereby authorize Jennifer Grant, D.D.S. to release my dental records and radiographs or copies of such and request that they be transferred to:

To: ___________________________________

Address: _____________________________

City: ____________ State: ____ Zip: _______

Phone: _____________ Fax: _____________

E-Mail: _______________________________

Name of Patient: ______________________________

Date of Birth: ________________________________

Signature: ___________________________________

Date of Request: ______________________________

Office Use Only

Date Request Received: _________________________

Date Request Processed: ________________________