

## Records Release

I, \_\_\_\_\_, authorize the release of dental records and current radiographs (or copies of such) relevant to dental treatment for myself and my dependents whose names are list below.

Names of Dependents:

I request that they be transferred to:

Gwynne Attarian DDS PLLC  
8641 W. Grand River Ave, Suite 3  
Brighton, MI 48116  
Phone: (810) 360-0330 Fax: (810) 229-2965  
Attariandentistry@secureds.com

Print Patient or Parent/Guardian Name: \_\_\_\_\_

Signature of Patient or Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Previous Dentist: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_