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
DrGwynne@attariandentsitry.com

Print Patient or Parent/Guardian Name: ____

Signature of Patient or Parent/Guardian: ____

Date: ____________________

Name of Previous Dentist: ____

Address: ____________________________________ City: ____________________ State: _____ Zip: ________

Phone: ___________________________ Fax: _________________________________