RECORDS RELEASE REQUEST

DATE:____

TO:____

ADDRESS:____

CITY:____________________STATE:________________ZIP:___________________

I authorize the release of copies of my dental X-rays and periodontal scaling and root planing treatments (if applicable) and request that they be sent to:

ADAM N. STILL, D.M.D., P.L.

2389 RINGLING BLVD., SUITE C
SARASOTA, FL 34237
Phone: 941-957-3311
Fax: 941-957-3310
E-Mail: information@smilesarasota.com

A fax or photo copy of this letter may serve as an original.

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Print Name of Patient

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Signature (patient, parent or guardian)