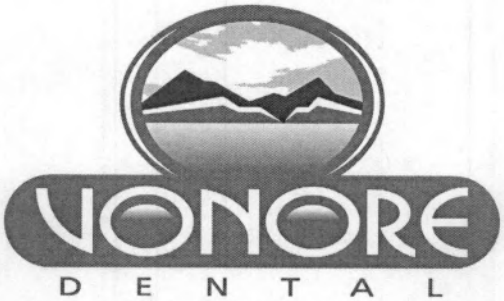

1277 Hwy 411
Vonore TN. 37885
423-884-2300
865-560-0075
Fax# 423-884-2981
vdpcare@gmail.com / vdp.kimt@gmail.com

Release of Dental Records

Request For Record(s)

Dr._____

Address:_____

City/State/ Zip:_____

Phone:_____ Fax: _____

E-Mail: _____

Patient Name: _____Date of Birth: _____

Patient Name: _____Date of Birth: _____

Patient Name: _____Date of Birth: _____

Patient Name: _____Date of Birth: _____

I authorize any and all information, records, x-rays, charts, test results, laboratory and/or clinical findings or evaluations concerning my Dental / Medical history: includes your findings, diagnosis, treatment, evaluations, opinions and prognosis related to treatment.

_____ _____

Patient / Guardian's Signature **Date**